PL 99-509
10/21/86

BERC

99TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
99-1012

PROVIDING FOR RECONCILIATION PURSUANT TO SECTION 2 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1987

CONFERENCE REPORT

TO ACCOMPANY

H.R. 5300



OCTOBER 17, 1986.—Ordered to be printed

Public Laws / House / Reports / 99th / H 87-1986

99TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
99-1012

OMNIBUS BUDGET RECONCILIATION ACT OF 1986

OCTOBER 17, 1986.—Ordered to be printed

Mr. GRAY of Pennsylvania, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 5300]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 5300) to provide for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Omnibus Budget Reconciliation Act of 1986".

(b) TABLE OF CONTENTS.—

Title I. Agriculture programs.
Title II. Banking and housing programs.
Title III. Energy and environmental programs.
Title IV. Transportation and related programs.
Title V. Maritime programs.
Title VI. Civil service, Postal Service, and governmental affairs generally.
Title VII. Fiscal procedures.
Title VIII. Revenues, trade, and related programs.
Title IX. Income security, medicare, medicaid, and maternal and child health programs.

64-554 O

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

ance with the provisions of the plan, merely because it operates in accordance with this subsection.

(d) INTERAGENCY COORDINATION.—The regulations and rulings issued by the Secretary of Labor, the regulations and rulings issued by the Secretary of the Treasury, and the regulations and rulings issued by the Equal Employment Opportunity Commission pursuant to the amendments made by this subtitle shall each be consistent with the others. The Secretary of Labor, the Secretary of the Treasury, and the Equal Employment Opportunity Commission shall each consult with the others to the extent necessary to meet the requirements of the preceding sentence.

(e) FINAL REGULATIONS.—The Secretary of Labor, the Secretary of the Treasury, and the Equal Employment Opportunity Commission shall each issue before February 1, 1988, such final regulations as may be necessary to carry out the amendments made by this subtitle.

Subtitle D—Provisions Relating to Medicare

TABLE OF CONTENTS

PART 1—PROVISIONS RELATING TO MEDICARE PART A ONLY

Sec. 9301. Changes in inpatient hospital deductible.
Sec. 9302. Applicable percentage increase in payments for inpatient hospital services.
Sec. 9303. Payments for hospital capital-related costs.
Sec. 9304. Coverage of hospitals in Puerto Rico under a DRG prospective payment system.
Sec. 9305. Improving quality of care with respect to part A services.
Sec. 9306. Payments to large rural hospitals serving a disproportionate share of low-income patients.
Sec. 9307. Technical amendments and miscellaneous provisions relating to part A.

PART 2—PROVISIONS RELATING TO PARTS A AND B

Sec. 9311. Periodic interim payment system (PIP) for DRG hospitals and prompt payment for medicare providers.
Sec. 9312. Health maintenance organizations and competitive medical plans.
Sec. 9313. Provisions relating to improvement of quality of care.
Sec. 9314. Direct costs of graduate medical education.
Sec. 9315. Payments for home health services.
Sec. 9316. Establishment of patient outcome assessment research program.
Sec. 9317. Improvements in civil monetary penalty and exclusion provisions.
Sec. 9318. Hospital protocols for organ procurement and standards for organ procurement agencies.
Sec. 9319. Medicare as secondary payer; coverage requirements for certain other payers.
Sec. 9320. Payment for services of certified registered nurse anesthetists.
Sec. 9321. Technical amendments and miscellaneous provisions relating to parts A and B.

PART 3—PROVISIONS RELATING TO MEDICARE PART B

Sec. 9331. Payment for physicians' services.
Sec. 9332. Incentives for physician participation.
Sec. 9333. Limits on reasonable charges.
Sec. 9334. Payment for cataract surgical procedures.
Sec. 9335. Payment rates for renal services and improvements in administration of end stage renal disease networks and program.
Sec. 9336. Vision care.
Sec. 9337. Occupational therapy services.
Sec. 9338. Services of a physician assistant.
Sec. 9339. Payment for clinical diagnostic laboratory tests.
Sec. 9340. Payment for parenteral and enteral nutrition supplies and equipment.
Sec. 9341. Changing medicare appeal rights.
Sec. 9342. Alzheimer's disease demonstration projects.

Sec. 9343. Payments for ambulatory surgery.
Sec. 9344. Technical amendments and miscellaneous provisions relating to part B.

PART 4—IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

Sec. 9351. PRO review of hospital denial notices.
Sec. 9352. PRO review of inpatient hospital services and early readmission cases.
Sec. 9353. PRO review of quality of care.

Part 1—Provisions Relating to Medicare Part A Only

SEC. 9301. CHANGES IN INPATIENT HOSPITAL DEDUCTIBLE.

(a) IN GENERAL.—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended to read as follows:

"(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

"(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

"(3) The inpatient hospital deductible for a year shall apply to—

"(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

"(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to inpatient hospital services and post-hospital extended care services furnished on or after January 1, 1987, and to the monthly premium (under part A of title XVIII of the Social Security Act) for months beginning with January 1987.

(c) PROMULGATION OF NEW DEDUCTIBLE.—The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act, for the publication of the inpatient hospital deductible, the coinsurance amounts for inpatient hospital services and post-hospital extended care services and the monthly part A premiums for 1987, as modified under the amendment made by subsection (a).

SEC. 9302. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

(a) APPLICABLE PERCENTAGE INCREASE.—

(1) IN GENERAL.—Subclause (II) of section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

"(II) for fiscal year 1987, 1.15 percent, and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and".

(2) CONFORMING AMENDMENTS.—(A) Section 1886(d)(3)(A) of such Act is amended by striking "and 1986" and inserting ", 1986, 1987, and 1988".

(B) Section 1886(e)(4) of such Act is amended by striking "determine for each fiscal year (beginning with fiscal year 1987)" and inserting "recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year".

(C) Section 1866(e)(5) of such Act is amended by inserting "recommendation or" before "determination" each place it appears.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act, for cost reporting periods beginning and discharges occurring on or after October 1, 1986.

(b) SEPARATE OUTLIER OFFSETS FOR URBAN AND RURAL HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(3)(B) of such Act is amended—

(A) by inserting "for hospitals located in an urban area and for hospitals located in a rural area" after "subparagraph (A)", and

(B) by inserting before the period the following: "for hospitals located in such respective area".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharges occurring on or after October 1, 1986.

(3) MAINTAINING CURRENT OUTLIER POLICY IN FISCAL YEAR 1987.—For payments made under section 1886(d) of the Social Security Act for discharges occurring in fiscal year 1987—

(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986.

(c) COMPUTING URBAN AND RURAL AVERAGES.—Section 1886(d)(3)(A) of such Act is amended by adding at the end the following: "With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been

made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(i).".

(d) REGIONAL REFERRAL CENTERS.—

(1) CRITERIA.—

(A) IN GENERAL.—Section 1886(d)(5)(C)(i) of such Act is amended—

(i) by inserting "(I)" after "(C)(i)", and

(ii) by adding at the end the following new subclause:

"(II) The Secretary shall provide, under subclause (I), for the classification of a rural hospital as a regional referral center if the hospital has a case mix equal to or greater than the median case mix for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in pargraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under subclause (I) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under subclause (I).".

(B) EFFECTIVE DATE.—(i) Subject to clause (ii), the amendments made by subparagraph (A) shall apply to payments for discharges occurring on or after October 1, 1986.

(ii) An appeal for classification of a rural hospital as a regional referral center, pursuant to the amendments made by subparagraph (A), which is filed before January 1, 1987, and which is approved shall be effective with respect to discharges occurring on or after October 1, 1986.

(2) EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION.—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act on the date of the enactment of this Act shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

(3) BUDGET-NEUTRAL IMPLEMENTATION.—Paragraph (2) and the amendment made by paragraph (1)(A) shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act are not increased or decreased by reason of the classifications required by such paragraph or amendment.

(4) RURAL SECONDARY SPECIALTY DEMONSTRATION PROJECT.—

(A) ESTABLISHMENT.—The Secretary of Health and Human Services (in this paragraph referred to as the "Secretary") shall enter into an agreement with Lake Region Hospital and Nursing Home at Fergus Falls, Minnesota, for the purpose of conducting a rural secondary specialty center demonstration project (in this paragraph referred to as the "project") under title XVIII of the Social Security Act.

(B) PURPOSE.—The purpose of this project shall be to determine the effect that a modified system of making pay-

ments under part A of such title to rural secondary specialty centers would have on—

(i) total expenditures under such part, and

(ii) the access of medicare beneficiaries located in rural areas to quality health care.

(C) PAYMENTS.—During the period of the demonstration project, payments under part A of such title shall be made under the project on the basis of average standardized amounts computed for urban areas in the region in which the project is conducted, as adjusted by a rural wage index.

(D) DURATION.—The project shall be of a maximum duration of three years.

(E) REPORTS.—The Secretary shall submit a final report to the Congress on the project not later than six months after the completion of the project.

(e) MISCELLANEOUS PROVISIONS.—

(1) ANNUAL ADJUSTMENT.—Section 1886(d)(4)(C) of such Act is amended by striking "in fiscal year 1986 and at least every four fiscal years" and inserting "in fiscal year 1988 and at least annually".

(2) CLARIFYING AUTHORITY TO VARY RATES.—Section 1886(e)(4) of such Act is amended by adding at the end the following new sentence: "The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.".

(3) NOTICE OF EARLIER PROMULGATION OF PERCENTAGE INCREASE.—Section 1886(e)(3) of such Act is amended—

(A) by inserting "(A)" after "(3)", and

(B) by adding at the end the following new subparagraph:

"(B) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the the percentage change that the Secretary will recommend or determine under paragraph (4) with respect to that fiscal year.".

(4) EXTENSION OF SOLE COMMUNITY PROVIDER PROVISION.—Section 1886(d)(5)(C)(ii) of such Act is amended by striking "1986" and inserting "1988".

(f) PROMULGATION OF NEW RATE.—The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act, for the publication of the payments rates that will apply under section 1886 of the Social Security Act, for discharges occurring on or after October 1, 1986, taking into account the amendments made by this section, without regard to the provisions of chapter 5 of title 5, United States Code.

SEC. 9303. PAYMENTS FOR HOSPITAL CAPITAL-RELATED COSTS.

(a) IN GENERAL.—Section 1886(g) of the Social Security Act (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

"(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

"(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

"(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988, and

"(iii) 10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989.

"(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(C)(ii)).

"(C) If the Secretary provides, under subsection (a)(4), for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

"(i) notwithstanding any other provision of this title, for the continuation of payment under the reasonable cost methodology described in section 1861(v)(1) with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

"(ii) in the design of such payment system that the aggregate payment amounts under this title for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this title that would have been made (taking into account the provisions of subparagraphs (A) and (B)) during that fiscal year but for the inclusion of such costs by the Secretary.".

(b) ADDITION OF PUERTO RICO HOSPITALS.—Effective for cost reporting periods beginning and discharges occurring (as the case may be) on or after October 1, 1987, section 1886(g)(3)(A) of the Social Security Act (as amended by subsection (a)) is amended by inserting "and a subsection (d) Puerto Rico hospital" after "subsection (d) hospital".

(c) CLARIFICATION OF SECRETARIAL AUTHORITY TO INCORPORATE PAYMENT FOR OTHER CAPITAL-RELATED COSTS UNDER THE PROSPECTIVE PAYMENT SYSTEM.—Section 1886(a)(4) of such Act is amended by striking "October 1, 1987" and inserting "October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select)".

SEC. 9304. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER A DRG PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges in a fiscal year beginning on or after October 1, 1987, is equal to the sum of—

"(i) 75 percent of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

"(ii) 25 percent of the discharge-weighted average of—

"(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in an urban area, and

"(II) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term 'subsection (d) Puerto Rico hospital' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

"(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

"(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

"(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

"(I) excluding an estimate of indirect medical education costs,

"(II) adjusting for variations among hospitals by area in the average hospital wage level,

"(III) adjusting for variations in case mix among hospitals, and

"(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(v) (relating to disproportionate share payments).

"(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

"(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

"(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

"(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

"(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

"(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

"(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

"(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

"(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

"(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

"(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level.

"(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this para-

graph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

"(i) Subparagraph (A) (relating to outlier payments).

"(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

"(iii) Subparagraph (C)(iii) (relating to exceptions and adjustments).

"(iv) Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).

"(v) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).".

(b) CONFORMING AMENDMENTS.—(1) The first sentence of subclause (I) of section 1886(d)(5)(C)(ii)(II) of such Act, as redesignated by section 9302(d), is amended by inserting "(other than under paragraph (9))" after "established under this subsection".

(2) The second and third sentences of section 1886(d)(5)(C)(ii) of such Act are each amended by inserting "(other than under paragraph (9))" after "payment amounts under this subsection".

(c) BUDGET NEUTRALITY.—Section 1886(e)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

"(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

"(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

"(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 1987.

SEC. 9305. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES.

(a) REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM.—

(1) DEVELOPMENT OF LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop and submit to Congress a specific legislative proposal to improve the classification and payment system under section 1886(d) of the Social Security Act (and, as appropriate, the system for payment of outliers under section 1886(d)(5)(A) of such Act) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner

for individual patients or classes of patients with similar conditions.

(2) ACCOUNTING FOR SEVERITY OF ILLNESS.—In developing the proposal, the Secretary shall account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) DEADLINE.—The proposal shall be submitted to Congress by not later than 2 years after the date of the enactment of this Act.

(b) REQUIRING NOTICE OF HOSPITAL DISCHARGE RIGHTS.—

(1) REQUIREMENT FOR HOSPITALS TO PROVIDE STATEMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by section 1895(b) of the Tax Reform Act of 1986 and by section 233 of the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, is amended—

(A) by striking "and" at the end of the subparagraph (K),

(B) by striking the period at the end of subparagraph (L) and inserting ", and", and

(C) by inserting after subparagraph (L) the following new subparagraph:

"(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

"(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

"(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

"(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

"(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify."

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act not later than six months after the date of the enactment of this Act. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide.

(c) REQUIRING HOSPITALS TO PROVIDE DISCHARGE PLANNING PROCESS.—

(1) REQUIREMENT AS CONDITION OF PARTICIPATION.—Section 1861(e)(6) of the Social Security Act (42 U.S.C. 1395x(e)(6)) is amended—

(A) by inserting "(A)" after "(6)", and

(B) by inserting before the semicolon at the end the following: "and (B) has in place a discharge planning process that meets the requirements of subsection (ee)".

(2) DISCHARGE PLANNING PROCESS DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

"Discharge Planning Process

"(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

"(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

"(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

"(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

"(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

"(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

"(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

"(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

"(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel."

(3) EFFECT OF ACCREDITATION.—The second sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended—

(A) by inserting ", requires a discharge planning process (or imposes another requirement which serves substantially the same purpose)" after "the same purpose)", and

(B) by inserting "clause (A) or (B) of" after "comply also with".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to hospitals as of one year after the date of the enactment of this Act.

(d) REVIEW OF STANDARDS FOR MEDICARE CONDITIONS OF PARTICIPATION FOR ASSURING QUALITY OF INPATIENT HOSPITAL SERVICES.—The Secretary of Health and Human Services shall arrange for a study of the adequacy of the standards used for hospitals, for purposes of meeting the conditions of participation under title XVIII of the Social Security Act, in assuring the quality of services furnished in hospitals. The Secretary shall report to Congress on the results of the study by not later than 2 years after the date of the enactment of this Act.

(e) STUDY OF PAYMENT FOR ADMINISTRATIVELY NECESSARY DAYS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine whether a payment should be made (in a budget-neutral manner under title XVIII of such Act to hospitals receiving payments under section 1886(d) of such Act) to a hospital for administratively necessary days, separate from the per-discharge and outlier payments made under such section.

(2) ADMINISTRATIVELY NECESSARY DAYS DEFINED.—In this subsection, an "administratively necessary day" is a day of continued inpatient hospital stay, for an individual entitled to benefits under part A of title XVIII of the Social Security Act, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(3) CONSIDERATIONS IN CONDUCTING STUDY.—In conducting the study, the Secretary shall consider—

(A) the need for such a payment in order to minimize—

(i) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care, and

(ii) the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility, and

(B) the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) REPORT ON STUDY.—The Secretary shall report to Congress on the results of the study not later than January 1, 1989.

(f) EXTENDING WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a hospice program should be denied pursuant to section 1862(a)(1)(C) of the Social Security Act, apply (under section 1879(a) of such Act) a presumption of compliance of 2.5 percent (based on the number of days of hospice care billed) in a

manner substantially similar to that provided to home health agencies under policies in effect as of July 1, 1985.

(2) EFFECTIVE DATE.—Paragraph (1) shall apply to hospice care furnished on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act and before November 1, 1988.

(g) EXTENSION OF WAIVER OF LIABILITY PROVISIONS TO CERTAIN COVERAGE DENIALS FOR HOME HEALTH SERVICES.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended—

(A) in subsection (a)(1), by inserting "or by reason of a coverage denial described in subsection (g)" after "section 1862(a)(1) or (9)";

(B) in the first sentence of subsection (a), by inserting "and as though the coverage denial described in subsection (g) had not occurred" before the period at the end;

(C) in the third sentence of subsection (a), by inserting "or by reason of a coverage denial described in subsection (g)" after "section 1862(a)(1) or (9)";

(D) in subsection (c), by inserting "or by reason of a coverage denial described in subsection (g)" after "section 1862(a)(1) or (9)"; and

(E) by adding at the end the following new subsections:

"(f)(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to any coverage denial described in subsection (g).

"(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

"(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

"(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

"(3) The requirements of this paragraph are as follows:

"(A) The agency complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

"(B) The agency program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

"(4) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

"(5) In this subsection, the term 'fiscal intermediary' means, with respect to a home health agency, an agency or organization with an agreement under section 1816 with respect to the agency.

"(g) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a

failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

"(1) is or was not confined to his home, or

"(2) does or did not need skilled nursing care on an intermittent basis."

(2) REPORTS.—The Secretary of Health and Human Services shall report to Congress annually in March of 1987 and 1988—

(A) information on the frequency and distribution (by type of provider) of denials of bills for payment under title XVIII of the Social Security Act for extended care services, home health services, and hospice care, by reason of section 1862(a)(1) or (9) of such Act and coverage denials described in section 1879(g) of such Act, including—

(i) the reasons for such denials,

(ii) the extent to which payments were nonetheless made because of section 1879 of such Act, and

(iii) the rate of reversals of such denials, and

(B) such other information as may be appropriate to evaluate the appropriateness of any percentage standards established for the granting of favorable presumptions with respect to such denials.

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to coverage denials occurring on or after July 1, 1987, and before October 1, 1989.

(h) DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a uniform needs assessment instrument that—

(A) evaluates—

(i) the functional capacity of an individual,

(ii) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and

(iii) the social and familial resources available to the individual to meet those requirements; and

(B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.

The Secretary may develop more than one such instrument for use in different situations.

(2) ADVISORY PANEL.—The Secretary shall develop any instrument in consultation with an advisory panel, appointed by the Secretary, that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.

(3) REPORT ON INSTRUMENT.—The Secretary shall report to Congress, not later than January 1, 1989, on the instrument or instruments developed under this section. The report shall make

recommendations for the appropriate use of such instrument or instruments.

(i) INCLUDING IN ANNUAL REPORTS ON PROSPECTIVE PAYMENT SYSTEM INFORMATION ON QUALITY OF POST-HOSPITAL CARE.—

(1) IN GENERAL.—Section 603(a)(2) of the Social Security Amendments of 1983 is amended—

(A) by striking "1987" in subparagraph (A) and inserting "1989", and

(B) by adding at the end the following new subparagraph:

"(E) In each annual report to Congress under subparagraph (A), the Secretary shall include—

"(i) an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under title XVIII of the Social Security Act,

"(ii) an assessment of problems that have prevented groups of medicare beneficiaries (including those eligible for medical assistance under title XIX of such Act) from receiving appropriate post-hospital services covered under such title, and

"(iii) information on considerations and appeals taken under title XVIII of such Act with respect to payment for post-hospital services.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(B) shall apply to reports for years beginning with 1986.

(k) PRIOR AND CONCURRENT AUTHORIZATION DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration program concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under part A or part B of title XVIII of the Social Security Act.

(2) SCOPE.—The program shall include at least four projects and shall be initiated by not later than January 1, 1987.

(3) CONSULTATION AND MONITORING.—The program shall be developed in consultation with an advisory panel that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries. The Secretary shall monitor the acceptance of individuals entitled to benefits under title XVIII of the Social Security Act by providers to ensure that the placement of such individuals is not delayed until the results of prior and concurrent review are known.

(4) EVALUATION AND REPORT.—The Secretary shall evaluate the demonstration program conducted under this subsection and shall report to Congress on such evaluation no later than February 1, 1989. Such evaluation and report shall address—

(A) the administrative and program costs for prior and concurrent authorization across demonstration projects and in comparison to administrative and program costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which

would not be incurred under prior or concurrent authorization;

(B) impact of prior or concurrent authorization on access to and availability of extended care services and home health services in comparison to the current system (including costs to providers) and on timely discharge of hospital inpatients; and

(C) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior or concurrent authorization versus the current system.

(5) FUNDING.—Expenditures made for the demonstration program shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection.

(6) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

SEC. 9306. PAYMENTS TO LARGE RURAL HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.

(a) QUALIFYING HOSPITALS.—Section 1886(d)(5)(F)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended by adding at the end the following new sentence: "A hospital located in a rural area and with 500 or more beds also 'serves a significantly disproportionate number of low income patients' for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.".

(b) PAYMENT AMOUNT.—Section 1886(d)(5)(F)(iv) of such Act is amended—

(1) in subclause (I), by inserting "or is described in the second sentence of subclause (III)" after "100 or more beds", and

(2) in subclause (III), by inserting " and is not described in the second sentence of clause (v)" after "rural area".

(c) EXTENSION OF DISPROPORTIONATE SHARE PROVISION.—Section 1886(d) of such Act is further amended, in paragraphs (2)(C)(iv), (3)(C)(ii), (5)(B)(ii), and (5)(F)(i), by striking "1988" each place it appears and inserting "1989".

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to discharges occurring on or after October 1, 1986.

SEC. 9307. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART A.

(a) TEMPORARY WAIVER OF INPATIENT LIMITATIONS FOR THE CONNECTICUT HOSPICE, INC.—With respect to the Connecticut Hospice, Inc., for hospice care provided before October 1, 1988, the reference in section 1861(dd)(2)(A)(iii) of the Social Security Act (42 U.S.C.

1395x(dd)(2)(A)(iii)) to "20 percent" is deemed a reference to "50 percent".

(b) MASSACHUSETTS MEDICARE REPAYMENT.—The Secretary of Health and Human Services shall not, on or after the date of the enactment of this section and before January 1, 1988, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the State-wide hospital reimbursement demonstration project conducted in that State, between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972.

(c) PART A COBRA TECHNICAL CORRECTIONS.—(1) Effective as if included in the enactment of the Tax Reform Act of 1986, if House Concurrent Resolution 395 (99th Congress, 2d Session) has not been adopted, section 1895(b) of the Tax Reform Act of 1986 is amended—

(A) by striking paragraph (1), and

(B) by striking subparagraphs (A) and (B) of paragraph (2).

(2) Effective as if included in the enactment of the Tax Reform Act of 1986—

(A) section 1895(b) of such Act is amended, in subparagraph (A)(ii) of the paragraph relating to "PHYSICIAN PAYMENT", by inserting before the period the following: "the first place it appears", and

(B) section 1895(d)(5)(A) of such Act is amended by striking "1862(k)(2)" and inserting "1862(k)(5)".

(3) If House Concurrent Resolution 395 (99th Congress, 2d Session) has been adopted, effective for discharges occurring on or after May 1, 1986, section 1886(d)(5)(F)(vi)(I) of the Social Security Act is amended—

(A) by striking "supplementary" and inserting "supplemental", and

(B) by striking "fiscal year" and inserting "period".

(4) Paragraphs (2) and (3) of section 1867(b) of the Social Security Act are amended by striking "legally responsible".

(d) MISCELLANEOUS ACCOUNTING PROVISION.—Effective on the date of the enactment of Public Law 99-107, in applying section 5(a) of such Act, a cost reporting period beginning on September 28, 29, or 30 is deemed to begin on October 1 and any reference to September 30 is deemed also to be a reference to September 27.

PART 2—PROVISIONS RELATING TO PARTS A AND B

SEC. 9311. PERIODIC INTERIM PAYMENT SYSTEM (PIP) FOR DRG HOSPITALS AND PROMPT PAYMENT FOR MEDICARE PROVIDERS.

(a) PERIODIC INTERIM PAYMENTS.—

(1) IN GENERAL.—Section 1815 of the Social Security Act (42 U.S.C. 1395g) is amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d)

Puerto Rico hospital (as defined in section 1886(d)(9)(A)) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

"(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1816, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

"(B) In the case of hospital that—

"(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section) of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

"(ii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

"(C) In the case of a hospital that—

"(i) is located in a rural area,

"(ii) has 100 or fewer beds, and

"(iii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

"(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986)) with respect to—

"(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B));

"(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system;

"(C) extended care services;

"(D) home health services; and

"(E) hospice care;

if the provider of such services elects to receive, and qualifies for, such payments.

"(3) In the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1886) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to claims received on or after July 1, 1987.

(3) TRANSITION.—Upon the request of a hospital which—

(A) as of June 30, 1987, is receiving payments under part A of title XVIII of such Act for inpatient hospital services on a periodic interim payment basis,

(B) requests continuation of payment on such basis, and

(C) is paid through an agency or organization with an agreement under section 1816 of such Act,

the Secretary of Health and Human Services shall continue payment on such a basis until not earlier than the end of the first period of three consecutive calendar months (beginning no earlier than April 1987) during all of which the agency or organization has met the requirements of section 1816(c)(2) of such Act (relating to prompt payment of claims).

(b) PROMPT PAYMENT OF CLAIMS UNDER PART A.—Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended—

(1) by inserting "(1)" after "(c)", and

(2) by adding at the end the following new paragraph:

"(2)(A) Each agreement under this section shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this title—

"(i) which are clean claims, and

"(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

"(B) In this paragraph:

"(i) The term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title.

"(ii) The term 'applicable number of calendar days' means—

"(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

"(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

"(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days, and

"(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days.

"(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, skilled nursing facility, home health agency, or hospice program that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.".

(c) PROMPT PAYMENT OF CLAIMS UNDER PART B.—Section 1842(c) of the Social Security Act (42 U.S.C. 1395u(c)) is amended—

(1) by inserting "(1)" after "(c)", and

(2) by adding at the end the following new paragraph:

"(2)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

"(i) which are clean claims, and

"(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

"(B) In this paragraph:

"(i) The term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

"(ii) The term 'applicable number of calendar days' means—

"(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

"(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

"(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians), and

"(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians).

"(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.".

(d) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) shall apply to claims received on or after November 1, 1986.

(2) Sections 1816(c)(2)(C)) and 1842(c)(2)(C) of the Social Security Act, as added by such amendments, shall apply to claims received on or after April 1, 1987.

(3) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act and contracts under section 1842

of such Act, and regulations, to such extent as may be necessary to implement the provisions of this Act on a timely basis.

SEC. 9312. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) REPEAL OF "2 FOR 1" CONVERSION REQUIREMENT FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Section 114(c)(2) of the Tax Equity and Fiscal Responsibility Act of 1982 is amended by adding at the end the following new subparagraph:

"(E) The preceding provisions of this paragraph shall not to apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.".

(b) REQUIRING THE PROVISION OF AN EXPLANATION OF ENROLLEE RIGHTS.—

(1) IN GENERAL.—Subsection (c)(3) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subparagraph:

"(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

"(i) the enrollee's rights to benefits from the organization,

"(ii) the restrictions on payments under this title for services furnished other than by or through the organization,

"(iii) out-of-area coverage provided by the organization,

"(iv) the organization's coverage of emergency services and urgently needed care, and

"(v) appeal rights of enrollees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1987, and shall apply to enrollments effected on or after such date.

(c) RESTRICTING WAIVER OF REQUIREMENT OF 50 PERCENT NON-MEDICARE ENROLLMENT.—

(1) RESTRICTION ON NEW WAIVERS.—Paragraph (2) of subsection (f) of such section is amended by striking all that follows "only" and inserting a dash and the following:

"(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

"(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.".

(2) SANCTIONS FOR NONCOMPLIANCE.—

(A) SUSPENSION OF ENROLLMENT OR PAYMENT FOR NEW ENROLLEES.—Such subsection is further amended by adding at the end the following new paragraph:

"(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals

under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.".

(B) TERMINATION OF CONTRACT.—Subsection (i)(1)(C) of such section is amended by striking "and (e)" and insert "(e), and (f)".

(3) EFFECTIVE DATES.—

(A) NEW RESTRICTION.—The amendment made by paragraph (1) shall apply to modifications and waivers granted after the date of the enactment of this Act.

(B) SANCTIONS FOR NONCOMPLIANCE.—The amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

(C) TREATMENT OF CURRENT WAIVERS.—In the case of an eligible organization (or successor organization) that—

(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act, a modification or waiver of the requirement imposed by paragraph (1) of that section, but

(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection,

the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization has complied, or made significant progress towards compliance, with such schedule of compliance, the Secretary may extend such waiver. If the Secretary determines that the organization has not complied with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act (as amended by this section) effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.

(d) REQUIRING PROMPT PAYMENT OF CLAIMS.—

(1) IN GENERAL.—Subsection (g) of such section is amended by adding at the end the following new paragraph:

"(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

"(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide

for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to risk-sharing contracts under section 1876 of the Social Security Act with respect to services furnished on or after January 1, 1987.

(e) REQUIRING ACCESS TO FINANCIAL RECORDS AND DISCLOSURE OF INTERNAL LOANS.—

(1) IN GENERAL.—Subsection (i)(3)(C) of such section is amended—

(A) by striking "and" at the end,

(B) by inserting "(i)" after "(C)", and

(C) by adding at the end the following new clauses:

"(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

"(iii) shall require the organizatlon to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contracts as of January 1, 1987.

(f) AUTHORITY TO IMPOSE CIVIL MONEY PENALTIES.—Subsection (i) of such section is amended by adding at the end the following new paragraph:

"(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.".

(g) STUDY OF AAPCC AND ACR.—The Secretary of Health and Human Services shall provide, through contract with an appropriate organization, for a study of the methods by which—

(1) the adjusted average per capita cost ("AAPCC", as defined in section 1876(a)(4) of the Social Security Act) can be refined to more accurately reflect the average cost of providing care to different classes of patients, and

(2) the adjusted community rate ("ACR", as defined in section 1876(e)(3) of such Act) can be refined.

The Secretary shall submit to Congress, by not later than January 1, 1988, specific legislative recommendations concerning methods by which the calculation of the AAPCC and the ACR can be refined.

(h) ALLOWING MEDICARE BENEFICIARIES TO DISENROLL AT A LOCAL SOCIAL SECURITY OFFICE.—The Secretary of Health and Human Services shall provide that individuals enrolled with an eli-

gible organization under section 1876 of the Social Security Act may disenroll, on and after June 1, 1987, at any local office of the Social Security Administration.

(i) USE OF RESERVE FUNDS.—Notwithstanding any provision of section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) to the contrary, funds reserved by an eligible organization under such section before the date of the enactment of this Act may be applied, at the organization's option, to offset the amount of any reduction in payment amounts to the organization effected under Public Law 99–177 during fiscal year 1986.

SEC. 9313. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE.

(a) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.—

(1) IN GENERAL.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new sentence: "Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.".

(2) TREATMENT OF COSTS OF UNSUCCESSFUL APPEAL.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1869(b) shall not be allowable as reasonable costs.".

(3) EFFECTIVE DATE.—The amendments made by this paragraph take effect on the date of the enactment of this Act.

(b) PERMITTING REVIEW OF TECHNICAL DENIALS.—

(1) IN GENERAL.—Section 1869 of such Act is further amended—

(A) in subsection (a), by inserting before "shall" the following: "and any other determination with respect to a claim for benefits under part A", and

(B) in subsection (b)(1)—

(i) by striking "or" at the end of subparagraph (B),

(ii) by inserting ", or" at the end of subparagraph (C), and

(iii) by inserting after subparagraph (C) the following new subparagraph:

"(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,".

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of the enactment of this Act.

(c) PROHIBITION OF CERTAIN PHYSICIAN INCENTIVE PLANS.—

(1) MAKING CERTAIN PLANS SUBJECT TO CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended—

(A) by striking "subsection (a)" each place it appears and inserting "subsection (a) or (b)",

(B) in subsection (a)(1), by striking "(h)(1)" and "(h)(2)" and inserting "(i)(1)" and "(i)(2)", respectively,

(C) in subsection (f), by striking "subsection (d)" and inserting "subsection (e)",

(D) by redesignating subsections (b) through (h) as subsections (c) through (i), respectively, and

(E) by inserting after subsection (a) the following new subsection:

"(b)(1) If a hospital, an eligible organization with a risk-sharing contract under section 1876, or an entity with a contract under section 1903(m) knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

"(A) are entitled to benefits under part A or part B of title XVII or to medical assistance under a State plan approved under title XIX,

"(B) in the case of an eligible organization or an entity, are enrolled with the organization or entity, and

"(C) are under the direct care of the physician,

the hospital or organization shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

"(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for individual described in such paragraph with respect to whom the payment is made."

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to—

(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act, and

(B) payments by eligible organizations or entities occurring on or after April 1, 1989.

(3) STUDY.—The Secretary of Health and Human Services shall report to Congress, not later than January 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians. The report shall—

(A) review the type of incentive arrangements in common use,

(B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and

(C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act, for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.

(d) STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall arrange for a study to design a strategy for reviewing and assuring the quality of care for which payment may be made under title XVIII of the Social Security Act.

(2) ITEMS INCLUDED IN STUDY.—Among other items, the study shall—

(A) identify the appropriate considerations which should be used in defining "quality of care";

(B) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care;

(C) develop prototype criteria and standards for defining and measuring quality of care;

(D) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care;

(E) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress;

(F) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care;

(G) review mechanisms available for promoting, coordinating, and supervising at the national level quality review and assurance activities; and

(H) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) REPORT.—The Secretary shall submit to Congress, not later than 2 years after the date of the enactment of this Act, a report on the study. Such report shall address the items described in paragraph (2) and shall include recommendations with respect to strengthening quality assurance and review activities for services furnished under the medicare program.

(4) ARRANGEMENTS FOR STUDY.—(A) The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(B) In developing plans for the conduct of the study, the Secretary shall assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring of the quality of care are consulted.

(5) COORDINATION.—The Secretary shall designate an office with responsibilities for coordinating studies, under this subsection and other authority, relating to the quality of services furnished to medicare and medicaid beneficiaries, in particular studies relating to the evaluation of the prospective payment system on the quality of health care provided to medicare beneficiaries. These responsibilities shall include assessing the feasibility and costs of alternative studies in relation to their importance, overseeing and coordinating access to needed data, and maintaining a clearinghouse for both public and private sector studies.

SEC. 9314. DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.

(a) CLARIFYING COUNTING OF TIME SPENT IN OUTPATIENT SETTINGS.—Section 1886(h)(4) of such Act, as amended by section 1895(b) of the Tax Reform Act of 1986, is amended by adding at the end the following new subparagraph:

"(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for approved residency training programs as of July 1, 1987.

SEC. 9315. PAYMENTS FOR HOME HEALTH SERVICES.

(a) LIMITATIONS ON PAYMENT FOR HOME HEALTH SERVICES.—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended—

(1) by inserting "(i)" after "(L)", and

(2) by striking "the 75th percentile" and all that follows through "as the Secretary may determine." and inserting in lieu thereof "for cost reporting periods beginning on or after—

"(I) July 1, 1985, and before July 1, 1986, 120 percent,

"(II) July 1, 1986, and before July 1, 1987, 115 percent, or

"(III) July 1, 1987, 112 percent,

of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.

"(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.".

(b) CONSIDERATIONS IN ESTABLISHING LIMITS.—In establishing limitations under section 1861(v)(1)(L) of the Social Security Act on payment for home health services for cost reporting periods beginning on or after July 1, 1986, the Secretary of Health and Human Services shall—

(1) base such limitations on the most recent data available, which data may be for cost reporting periods beginning no earlier than October 1, 1983; and

(2) take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent the changes in costs are not reflected in such data.

Paragraph (2) shall apply to changes in requirements effected before, on, or after July 1, 1986.

(c) GAO REPORT.—The Comptroller General shall study and report to Congress, not later than February 1, 1988, on—

(1) the appropriateness and impact on medicare beneficiaries of applying the per visit cost limits for home health services under section 1861(v)(1)(L) of the Social Security Act on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and

(2) the appropriateness of the percentage limits established under such section.

SEC. 9316. ESTABLISHMENT OF PATIENT OUTCOME ASSESSMENT RESEARCH PROGRAM.

(a) IN GENERAL.—Section 1875 of the Social Security Act (42 U.S.C. 1395ll) is amended by adding at the end the following new subsection:

"(c)(1) The Secretary shall establish a patient outcome assessment research program (in this subsection referred to as the 'research program') to promote research with respect to patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness. The research program shall include—

"(A) reorganization of data relating to claims under parts A and B of this title in a manner that facilitates research with respect to patient outcomes,

"(B) assessments of the appropriateness of admissions and discharges,

"(C) assessments of the extent of professional uncertainty regarding efficacy,

"(D) development of improved methods for measuring patient outcomes,

"(E) evaluations of patient outcomes, and

"(F) evaluation of the effects on physicians' practice patterns of the dissemination to physicians and peer review organizations with contracts under part B of title XI of the findings of the research conducted under subparagraphs (B), (C), (D), and (E).

"(2) In selecting treatments and procedures to be studied, the Secretary shall give priority to those medical and surgical treatments and procedures—

"(A) for which data indicate a highly (or potentially highly) variable pattern of utilization among beneficiaries under this title in different geographic areas, and

"(B) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the research program, and risk involved to the beneficiary.

"(3) For purposes of carrying out the research program, there are authorized to be appropriated—

"(A) from the Federal Hospital Insurance Trust Fund $4,000,000 for fiscal year 1987 and $5,000,000 for each of fiscal years 1988 and 1989, and

"(B) from the Federal Supplementary Medical Insurance Trust Fund $2,000,000 for fiscal years 1987 and $2,500,000 for each of fiscal years 1988 and 1989.

"(4) Not less than 90 percent of the amount appropriated for any fiscal year to carry out the research program shall be used to fund grants to, and cooperative agreements with, non-Federal entities to conduct research described in paragraph (1). The remainder may be used by the Secretary to provide such research by Federal entities and for administrative costs.

"(5) The research program shall be administered by the National Center for Health Services Research and Health Care Technology established under section 305 of the Public Health Service Act (in this subsection referred to as the 'Center'). The Center shall establish application procedures for grants and cooperative agreements, and shall establish peer review panels to review all such applications and all research findings. The Center shall consult with the council on health care technology (established under a grant under section 309 of the Public Health Service Act) in establishing the scope and priorities for the research program and shall report periodically to any such council on the status of the program.

"(6) The Secretary shall make available data derived from the programs under this title and other programs administered by the Secretary for use in the research program.

"(7) The Center shall report to the Committees on Finance and Appropriations of the Senate and the Committees on Ways and Means, Energy and Commerce, and Appropriations of the House of Representatives not later than 18 months after the date of the enactment of this Act, and annually thereafter, with respect to the findings under the research program. In cooperation with appropriate medical specialty groups, the Center shall disseminate such findings as widely as possible, including disseminating such findings to each peer review organization which has a contract under part B of title XI."

(b) PERMITTING SERVICES TO BE PROVIDED UNDER RESEARCH PROGRAM.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (C),

(2) by striking the semicolon at the end of subparagraph (D) and inserting "; and", and

(3) by adding at the end the following new subparagraph:

"(E) in the case of research conducted pursuant to section 1875(c), which is not reasonable and necessary to carry out the purposes of that section;".

SEC. 9317. IMPROVEMENTS IN CIVIL MONETARY PENALTY AND EXCLUSION PROVISIONS.

(a) COLLATERAL ESTOPPEL EFFECT OF PRIOR FEDERAL CRIMINAL CONVICTIONS.—Section 1128A(c) of the Social Security Act (42 U.S.C. 1320a-7a(c)), as redesignated by section 9313(c), is amended by adding at the end the following new paragraph:

"(3) In a proceeding under subsection (a) or (b) which—

"(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statments, and

"(B) involves the same transaction as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.".

(b) AUTHORITY OF HEARING OFFICER TO SANCTION MISCONDUCT.—Such section is further amended by adding at the end the following new paragraph:

"(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

"(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

"(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

"(C) striking pleadings, in whole or in part,

"(D) staying the proceedings,

"(E) dismissal of the action,

"(F) entering a default judgment,

"(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

"(H) refusing to consider any motion or other action which is not filed in a timely manner.".

(c) CLARIFICATION OF EXCLUSION AUTHORITY FOR CERTAIN OFFENDERS.—Section 1128 of such Act (42 U.S.C. 1320a-7) is amended by adding at the end the following new subsection:

"(f) For purposes of subsection (a), a physician or other individual is considered to have been 'convicted' of a criminal offense—

"(1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

"(2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court;

"(3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; or

"(4) when the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld.".

(d) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall take effect on the date of the enactment of this Act, without regard to when the criminal conviction was obtained, but shall only apply to a conviction upon a plea of nolo contendere tendered after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to failures or misconduct occurring on or after the date of the enactment of this Act.

(3) The provisions—

(A) of paragraphs (1), (2), and (3) of section 1128(f) of the Social Security Act (as added by the amendment made by subsection (c)) shall apply to judgments entered, findings made, and pleas entered, before, on, or after the date of the enactment of this Act, and

(B) of paragraph (4) of such section shall apply to participation in a program entered into on or after the date of the enactment of this Act.

SEC. 9318. HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1137 the following new section:

"HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES

"SEC. 1138. (a)(1) The Secretary shall provide that a hospital meeting the requirements of title XVIII or XIX may participate in the program established under such title only if—

"(A) the hospital establishes written protocols for the identification of potential organ donors that—

"(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

"(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

'(iii) require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) be notified of potential organ donors; and

"(B) In the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 372 of the Public Health Service Act (in this section referred to as the 'Network').

"(2) For purposes of this subsection, the term 'organ' means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

"(b)(1) The Secretary shall provide that payment may be made under title XVIII or XIX with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

"(A)(i) is a qualified organ procurement organization (as described in section 371(b) of the Public Health Service Act) that is operating under a grant made under section 371(a) of such Act, or (ii) has been certified or recertified by the Secretary within the previous two years as meeting the standards to be a qualified organ procurement organization (as so described);

"(B) meets the requirements that are applicable under such title for organ procurement agencies;

"(C) meets performance-related standards prescribed by the Secretary;

"(D) is a member of, and abides by the rules and requirements of, the Network;

"(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

"(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such title.

"(2) The Secretary may not designate more than one organ procurement organization for each service area (described in section 371(b)(1)(E) of the Public Health Service Act) under paragraph (1)(F).".

(b) EFFECTIVE DATES.—(1) Section 1138(a) of the Social Security Act shall apply to hospitals participating in the programs under titles XVIII and XIX of such Act as of October 1, 1987.

(2) Section 1138(b) of such Act shall apply to costs of organs procured on or after October 1, 1987.

SEC. 9319. MEDICARE AS SECONDARY PAYER; COVERAGE REQUIREMENTS FOR CERTAIN OTHER PAYERS.

(a) MEDICARE SECONDARY FOR DISABLED EMPLOYEES OF CERTAIN LARGE EMPLOYERS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

"(4)(A)(i) A large group health plan may not take into account that an active individual is eligible for or receives benefits under this title under section 226(b), other than an individual who is, or would upon application be, entitled to benefits under section 226A.

"(ii) Payment may not be made under this title, except as provided in clause (iii), with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under clause (i).

"(iii) Any payment under this title with respect to any item or service to which clause (i) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title. In order to recover payment made under this title for the item or service, the United States may bring an action against any entity which is required under this subsection (a) to pay with respect to the item or service (and may, in accordance with paragraph (5), collect double damages against that entity), or against any other entity

that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States shall be subrogated (to the extent of payment made under this title for an item or service) to any right under clause (i) of an individual or any other entity to payment with respect to the item or service. The Secretary may waive (in whole or in part) the provisions of this clause in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

"(B) In this paragraph:

"(i) The term 'large group health plan' has the meaning given such term in section 5000(b) of the Internal Revenue Code of 1986.

"(ii) The term 'active individual' means an employee (as may be defined in regulations), the employer, an individual associated with the employer in a business relationship, or a member of the family of any of those persons.

"(C) The provisions of subparagraph (B) of paragraph (3) shall apply to coordination of payment under this paragraph in the case of large group health plans in the same manner as they apply to coordination of payment under paragraph (3) in the case of group health plans.

"(D) The preceding provisions of this paragraph shall only apply to items and services furnished on or after January 1, 1987, and before January 1, 1992.".

(b) ESTABLISHMENT OF PRIVATE CAUSE OF ACTION WHERE MEDICARE SECONDARY.—Such section is further amended by adding at the end the following new paragraph:

"(5) There is hereby created a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a workmen's compensation law or plan, automobile or liability insurance policy or plan or no fault insurance plan, group health plan, or large group health plan which is made a primary payer under paragraph (1), (2), (3), or (4), respectively, and which fails to provide for primary payment (or appropriate reimbursement) in accordance with such respective paragraphs."

(c) SPECIAL ENROLLMENT PERIODS.—

(1) Section 1837(i)(1) of such Act (42 U.S.C. 1395p(i)(1)) is amended by adding at the end the following: "In the case of an individual who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).".

(2) Section 1837(i)(2) of such Act (42 U.S.C. 1395p(i)(2)) is amended by adding at the end the following: "In the case of an individual who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during

any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan as an active individual, there shall be a special enrollment period described in paragraph (3)(B).".

(3) Section 1837(i)(3) of such Act (42 U.S.C. 1395p(i)(3)) is amended—

(A) by inserting "(A)" after "(3)",

(B) by inserting "the first sentences of" after "referred to in", and

(C) by adding at the end the following new subparagraph:

"(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled as an active individual in a large group health plan (as such terms are defined in section 1862(b)(4)(B)) and ending seven months later.".

(4) The second sentence of section 1839(b) of such Act (42 U.S.C. 1395r(b)) is amended by inserting before the period the following: "or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B))".

(d) TAX IMPOSED ON NONCONFORMING PLANS.—

(1) Subtitle D of the Internal Revenue Code of 1954 (relating to miscellaneous excise taxes) is amended by adding at the end the following new chapter:

"CHAPTER 47—CERTAIN LARGE GROUP HEALTH PLANS

"Sec. 5000. Certain large group health plans.

"SEC. 5000. CERTAIN LARGE GROUP HEALTH PLANS.

"(a) IMPOSITION OF TAX.—There is hereby imposed on any employer or employee organization that contributes to a nonconforming large group health plan a tax equal to 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each large group health plan to which the employer or employee organization contributes.

"(b) LARGE GROUP HEALTH PLAN.—For purposes of this section, the term 'large group health plan' means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

"(c) NONCONFORMING LARGE GROUP HEALTH PLAN.—For purposes of this section, the term 'nonconforming large group health plan'

means a large group health plan that at any time during a calendar year does not comply with the requirements of section 1862(b)(3)(A)(i) of the Social Security Act.

"(d) GOVERNMENT ENTITIES.—For purposes of this section, the term 'employer' does not include a Federal or other governmental entity."

(2) The table of chapters of subtitle D of such Code is amended by adding at the end thereof the following:

"CHAPTER 47. Certain large group health plans.".

(e) STUDY OF IMPACT ON DISABLED BENEFICIARIES AND FAMILY.—The Comptroller General shall study and report to Congress, by not later than March 1, 1990, the impact of the amendments made by this section on access of disabled individuals and members of their family to employment and health insurance. The report shall include information relating to—

(1) the number of disabled medicare beneficiaries for whom medicare has become secondary, either through their employment or the employment of a family member;

(2) the amount of savings to the medicare program achieved annually through this provision; and

(3) the effect on employment, and employment-based health coverage, of disabled individuals and family members.

(f) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to items and services furnished on or after January 1, 1987.

(2) The amendments made by subsection (c) shall apply to enrollments occurring on or after January 1, 1987.

SEC. 9320. PAYMENT FOR SERVICES OF CERTIFIED REGISTERED NURSE ANESTHETISTS.

(a) EXTENSION OF PASS-THROUGH FOR COSTS OF CERTIFIED REGISTERED NURSE ANESTHETISTS.—Section 2312(c) of the Deficit Reduction Act of 1984 is amended by striking "October 1, 1987." and inserting "January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but end after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date.".

(b) COVERAGE OF SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST UNDER PART B.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(1) by redesignating paragraphs (11) through (14) as paragraphs (12) through (15), respectively;

(2) by striking "and" at the end of paragraph (9);

(3) by striking the period at the end of paragraph (10) and inserting "; and"; and

(4) by inserting after paragraph (10) the following new paragraph:

"(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));".

(c) DEFINITION OF SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST.—Section 1861 of such Act is amended by inserting after subsection (aa) the following new subsection:

"SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST

"(bb)(1) The term 'services of a certified registered nurse anesthetist' means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

"(2) The term 'certified registered nurse anesthetist' means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.".

(d) DIRECT PAYMENT FOR SERVICES.—Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(1) by striking "and" at the end of clause (i),

(2) by striking "; and" at the end of clause (ii) and inserting ", and", and

(3) by adding at the end the following new clause:

"(iii) services of a certified registered nurse anesthetist; and".

(e) AMOUNT OF PAYMENT.—(1) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking "and' at the end of subparagraph (E), and by adding at the end the following: "and (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule for such services established by the Secretary in accordance with subsection (l),".

(2) Section 1833 of such Act is further amended by adding at the end the following new subsection:

"(l)(1) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

"(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985. The fee schedule shall be adjusted annually (to become effective on January 1 of each calendar year) by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for that year.

"(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

"(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable co-

insurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

"(4) In establishing the fee schedule under paragraph (1), the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology. The Secretary may establish a nationwide fee schedule or adjust the fee schedule for geographic areas (as the Secretary may determine to be appropriate).

"(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, physician, or group practice with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, or group practice.

"(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an assignment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

"(ii) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil monetary penalty of not to exceed $2,000 for each such bill or request. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.

"(C) No hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

"(6)(A) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, (subject to subparagraph (D)), the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) 1/2 of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.

"(B) In subparagraph (A), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in subparagraph (A).

"(C) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(D) This paragraph shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(3) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)) is amended by striking "paragraph (1) or subsection (k)" and inserting ", this paragraph".

(f) NOT TREATED AS PART OF INPATIENT HOSPITAL SERVICES.—Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by inserting before the semicolon the following: ", anesthesia services provided by a certified registered nurse anesthetist".

(g) CONFORMING AMENDMENTS TO HOSPITAL PAYMENTS.—(1) Section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4)) is amended by striking ", costs of anesthesia services provided by a certified registered nurse anesthetist,".

(2) Section 1886(d)(5) of such Act (42 U.S.C. 1395ww(d)(5)) is amended by striking subparagraph (E).

(h) OTHER CONFORMING AMENDMENTS.—(1) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by inserting before the period the following: "or are services of a certified registered nurse anesthetist".

(2) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by inserting ", and other than services of a certified registered nurse anesthetist" after "1862(a)(14)".

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (11) and (12)" and inserting "paragraphs (12) and (13)".

(i) EFFECTIVE DATE.—The amendments made by this section (other than subsection (a)) shall apply to services furnished on or after January 1, 1989.

(j) CONSTRUCTION.—Nothing in this section or the amendments made by this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.

SEC. 9321. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PARTS A AND B.

(a) TREATMENT OF GROUP PURCHASING VENDOR AGREEMENTS.—

(1) IN GENERAL.—Section 1877(b)(3) of the Social Security Act (42 U.S.C. 1395nn(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (A),

(B) by striking the period at the end of subparagraph (B) and inserting "; and", and

(C) by adding at the end the following:

"(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under this title if—

"(i) the person has a written contract, with each such individual or entity which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

"(ii) in the case of an entity that is a provider of services, the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to payments made before, on, or after the date of the enactment of this Act.

(b) EXTENSION AND CLARIFICATION OF COMPETITIVE CONTRACTING AUTHORITY.—Section 2326(a) of the Deficit Reduction Act of 1984 is amended—

(1) by striking "of the fiscal years" and all that follows through ", the Secretary" and inserting "fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1989), the Secretary", and

(2) by inserting "or cost reimbursement provisions under sections 1816(c) or 1842(c) of such Act" after "such Act" the second place it appears.

(c) TREATMENT OF CAPITAL-RELATED REGULATIONS.—

(1) PROHIBITION OF ISSUANCE OF FINAL REGULATIONS ON CAPITAL-RELATED COSTS AS PART OF PAYMENT FOR OPERATING COSTS BEFORE SEPTEMBER 1, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before September 1, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act. Any regulation published in violation of the previous sentence before the date of the enactment of this Act is void and of no effect.

(2) NOT INCLUDING CAPITAL-RELATED REGULATIONS IN BUDGET BASELINE.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

(3) EXCEPTION.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1886(g)(3)(A) and (B) of the Social Security Act (as amended by section 9303(a) of this Act).

(4) CAPITAL-RELATED COSTS DEFINED.—In this subsection, the term "capital-related costs" means those capital-related costs that are specifically excluded, under the second sentence of "operating costs of inpatient hospital services" (as defined in that section) for cost reporting periods beginning prior to October 1, 1987.

(d) LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1988 of more than $50,000,000, and which relates to hospitals or physicians.

(e) 60-DAY NOTICE FOR PROPOSED REGULATIONS.—

(1) IN GENERAL.—Section 1871 of the Social Security Act (42 U.S.C. 1395hh) is amended by inserting "(a)" after "1871." and by adding at the end the following new subsection:

"(b)(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

"(2) Paragraph (1) shall not apply where—

"(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

"(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

"(C) subsection (b) of section 553 of title 5, United States Code, does not apply pursuant to subparagraph (B) of such subsection.".

(2) CONFORMING AMENDMENTS.—(A) Section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)) is amended by striking "April" and inserting "March".

(B) Section 1886(e)(5)(A) of such Act is amended by striking "June" and inserting "May".

(3) EFFECTIVE DATES.—

(A) The amendments made by paragraph (1) shall apply to notices of proposed rulemaking issued after the date of the enactment of this Act.

(B) The amendments made by paragraph (2) shall take effect beginning with fiscal year 1989.

Part 3—Provisions Relating to Medicare Part B

SEC. 9331. PAYMENT FOR PHYSICIANS' SERVICES.

(a) DETERMINATION OF MAXIMUM ALLOWABLE PREVAILING CHARGES FOR PHYSICIANS' SERVICES.—

(1) IN GENERAL.—Section 1842(b)(4)(A) of the Social Security Act (42 U.S.C. 1395u(b)(4)(A)) is amended by striking clause (iii) and inserting the following:

"(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the

fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

"(iv) In determining the prevailing charge level under the third and fourth sentences of paragraph (3) for a physicians' service furnished on or after January 1, 1987, by a nonparticipating physician, the Secretary shall set the level at 96 percent of the prevailing charge levels established under such sentences with respect to such service furnished by participating physicians.

"(v) Beginning with 1987, the percentage increase in the MEI (as defined in subparagraph (E)(ii)) for each year shall be the same for nonparticipating physicians as for participating physicians.".

(2) CONFORMING AMENDMENT.—Section 1842(b)(4)(C) of such Act is amended—

(A) by striking "(i)" after "(C)", and

(B) by striking clause (ii).

(3) DEFINITIONS.—Section 1842(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

"(E) In this section:

"(i) The term 'participating physician' refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)), and the term 'nonparticipating physician' refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician.

"(ii) The term 'percentage increase in the MEI' means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of paragraph (3)) applicable to such services furnished as of the first day of that year.".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

(b) GENERAL LIMIT ON ACTUAL CHARGES FOR NONPARTICIPATING PHYSICIANS.—

(1) IN GENERAL.—Section 1842(j)(1) of such Act is amended—

(A) by inserting "(A)" after "(j)(1)", and

(B) by adding at the end the following new subparagraph:

"(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor each such physician's actual charges for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills for such a service a physician's actual charge (as defined in subparagraph (C)(vi) in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

"(ii) Clause (i) shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.

"(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's actual charge for that service in the previous year was—

"(I) less than 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

"(II) equal to, or greater than, 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

"(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's maximum allowable actual charge for the service for the previous year.

"(iii) In clause (ii), the 'applicable fraction' is—

"(I) for 1987, ¼,

"(II) for 1988, ⅓,

"(III) for 1989, ⅖, and

"(IV) for any subsequent year, 1.

"(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the 'maximum allowable actual charge' for 1986 is the physician's actual charge for such service furnished during such quarter.

"(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1987, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the 'maximum allowable actual charge' for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

"(vi) For purposes of this subparagraph and subparagraph (B), a 'physician's actual charge' for a physicians' service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning

April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.".

(2) PROVISION OF ACTUAL CHARGE INFORMATION BY CARRIER TO NONPARTICIPATING PHYSICIANS.—Section 1842(b)(3) of such Act is amended—

(A) by striking "and" at the end of subparagraph (E),

(B) by inserting "and" at the end of subparagraph (F), and

(C) by inserting after subparagraph (F) the following new subparagraph:

"(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's maximum allowable actual charges (established under subsection (j)(1)(C)) for the year for the physicians' services mostly commonly furnished by that physician;".

(3) CONFORMING AMENDMENT.—Section 1842(b)(4)(D) of such Act is amended by adding at the end the following new clause:

"(iv) In determining the customary charges for a physicians' service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

(c) MEDICARE ECONOMIC INDEX.—

(1) FOR 1987.—Notwithstanding any other provision of law, for purposes of part B of title XVIII of the Social Security Act for physicians' services furnished in 1987, the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii) of the Social Security Act) shall be 3.2 percent.

(2) PROHIBITING RETROACTIVE ADJUSTMENT OF MEDICARE ECONOMIC INDEX.—The Secretary of Health and Human Services is not authorized to revise the MEI in a manner that provides, for any period before January 1, 1985, for the substitution of a rental equalence or rental substitution factor for the housing component of the consumer price index.

(3) ANNUALIZATION OF MEI.—(A) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting after "ending June 30, 1973," the following: "or (with respect to physicians services furnished in a year after 1987) the level determined under this sentence for the previous year", and inserting "year-to-year" before "economic changes".

(B) The amendments made by subparagraph (A) shall apply to physicians' services furnished on or after January 1, 1988.

(4) STUDY.—The Secretary shall conduct a study of the extent to which the MEI appropriately and equitably reflects economic changes in the provision of the physicians' services to medicare beneficiaries. In conducting such study the Secretary shall consult with appropriate experts.

(5) LIMITATION ON CHANGES IN MEI METHODOLOGY.—The Secretary shall not change the methodology (including the basis and elements) used in the MEI from that in effect as of October 1, 1985, until completion of the study under paragraph (4). After the completion of the study, the Secretary may not change such methodology except after providing notice in the Federal Register and opportunity for public comment.

(6) MEI DEFINED.—In this subsection, the term "MEI" means the economic index referred to in the fourth sentence of section 1842(b)(3) of the Social Security Act.

(d) DEVELOPMENT AND USE OF HCFA COMMON PROCEDURE CODING SYSTEM.—

(1) Not later than July 1, 1989, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary"), after public notice and opportunity for public comment and after consulation with appropriate medical and other experts, shall group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered.

(2) Not later than January 1, 1990, each carrier with which the Secretary has entered into a contract under section 1842 of the Social Security Act shall make payments under part B of title XVIII of such Act based on the grouping of procedure codes effected under paragraph (1).

(e) RECOMMENDATIONS.—

(1) Section 1845(e) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(4)(A) In making recommendations with respect to the application of the relative value scale for purposes of establishing a fee schedule, the Secretary shall—

"(i) develop and assess an appropriate index to be used for making adjustments to reflect justifiable differences in the costs of practice based upon geographic location without exacerbating the geographic maldistribution of physicians, and

"(ii) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas.

"(B) In carrying out the requirements of subparagraph (A), the Secretary shall take into consideration the recommendations made by the Physician Payment Review Commission.

"(C)(i) The Secretary shall develop an interim index under subparagraph (A)(i) prior to January 1, 1988, based upon the most accurate and recent data that are available with respect to the costs of practice.

"(ii) The Secretary shall collect data with respect to the costs of practice (including, but not limited to, data on nonphysician personnel costs, malpractice insurance costs, and commercial rents) for the purpose of refining the index under subparagraph (A)(i) prior to December 31, 1989, and periodically updating the index thereafter.

"(D) In conjunction with developing an index under subparagraph (A), the Secretary shall conduct a study of the advisability of redefining the localities designated by carriers for payment purposes.".

(2) Section 1845(b)(3) of such Act is amended by inserting "and respecting the index and the adjustment described in subsection (e)(4)(A)" after "subsection (e)".

(3) Section 1845(e)(3) of such Act is amended—

(A) by striking "July 1, 1987" and inserting in lieu thereof "July 1, 1989"; and

(B) by striking "on or after January 1, 1988" and inserting in lieu thereof "after December 31, 1989".

SEC. 9332. INCENTIVES FOR PHYSICIAN PARTICIPATION.

(a) RECRUITING.—

(1) CARRIER RESPONSIBILITY.—Section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)), as amended by section 9331(b)(2), is further amended—

(A) by striking "and" at the end of subparagraph (F),

(B) by inserting "and" at the end of subparagraph (G), and

(C) by inserting after subparagraph (G) the following new subparagraph:

"(H) if it makes determinations or payments with respect to physicians' services, will implement—

"(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

"(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;".

(2) MEASURING CARRIER PERFORMANCE.—The Secretary of Health and Human Services shall provide, in the standards and criteria established under section 1842(b)(2) of the Social Security Act for contracts under that section, a system to measure a carrier's performance of the responsibilities described in sections 1842(b)(3)(H) and 1842(h) of such Act.

(3) CARRIER BONUSES FOR GOOD PERFORMANCE.—Of the amounts appropriated for administrative activities to carry out part B of title XVIII of the Social Security Act, the Secretary of Health and Human Services shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under section 1842 of such Act, to reward such carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians.

(4) EFFECTIVE DATES.—

(A) CARRIER RESPONSIBILITY.—The amendment made by paragraph (1) shall be effective for contracts under section 1842 of the Social Security Act as of October 1, 1987.

(B) PERFORMANCE MEASURES.—The Secretary of Health and Human Services shall provide for the establishment of the standards and criteria required under paragraph (2) by not later than October 1, 1987, which shall apply to contracts as of October 1, 1987.

(C) CARRIER BONUSES.—From the amounts appropriated for each fiscal year (beginning with fiscal year 1988), the Secretary of Health and Human Services shall first provide for payments of bonuses to carriers under paragraph (3) not later than April 1, 1988, to reflect performance of carriers during the enrollment period at the end of 1987.

(b) DIRECTORIES OF PARTICIPATING PHYSICIANS.—

(1) REQUIRING DISTRIBUTION TO MEDICARE BENEFICIARIES, UPON REQUEST.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended—

(A) in paragraph (2), by striking period and inserting the following: "and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request.";

(B) in paragraph (5)—

(i) by striking "publication of the directories" and inserting "the participation program under this subsection and the publication and availability of the directories", and

(ii) by adding at the end the following: "The Secretary shall include such notice in the mailing of appropriate benefit checks provided under title II."; and

(C) in the second sentence of paragraph (6)—

(i) by inserting before the period the following: "and that an appropriate number of copies of each such directory is sent to hospitals located in the area", and

(ii) by adding at the end the following: "Such copies shall be sent free of charge.".

(2) ORGANIZATION OF DIRECTORIES.—Section 1842(h)(4) of such Act is amended by adding at the end the following: "Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.".

(3) EFFECTIVE DATES.—The amendments made by this paragraph shall first apply to directories for 1987.

(c) PROHIBITING UNASSIGNED BILLING OF SERVICES DETERMINED TO BE MEDICALLY UNNECESSARY BY A CARRIER.—

(1) IN GENERAL.—Section 1842 of the Social Security Act is further amended by adding at the end the following new subsection:

"(l)(1)(A) Subject to subparagraph (C), if—

"(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

"(ii) payment for such services is not accepted on an assignment-related basis,

"(iii) a carrier determines under this part or a peer review organization determines under part B of title XI that payment

may not be made by reason of section 1862(a)(1) because a service otherwise covered under this title is not reasonable and necessary under the standards described in that section, and

"(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

"(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

"(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

"(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

"(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual if—

"(i) the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or

"(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

"(2) Each carrier with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

"(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 1987.

(d) DISCLOSURE OF INFORMATION OF UNASSIGNED CLAIMS FOR CERTAIN PHYSICIANS' SERVICES.—

(1) IN GENERAL.—Section 1842 of the Social Security Act, as amended by subsection (c)(1), is further amended by adding at the end the following new subsection:

"(m)(1) In the case of a nonparticipating physician who—

"(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

"(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to

the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

"(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

"(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (jX2).

"(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to surgical procedures performed on or after October 1, 1987.

(e) MAINTENANCE AND USE OF PARTICIPATING PHYSICIAN DIRECTORIES BY HOSPITALS.—

(1) REQUIREMENT OF PARTICIPATION.—Section 1866(aX1) of the Social Security Act, as amended by section 9305(bX1), is further amended—

(A) by striking "and" at the end of subparagraph (L),

(B) by striking the period at the end of subparagraph (M) and inserting ", and", and

(C) by inserting after subparagraph (M) the following new subparagraph:

"(N) in the case of hospitals—

"(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(hX4)) for the area served by the hospital, and

"(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to agreements under section 1866(a) of the Social Security Act as of October 1, 1987.

SEC. 9333. LIMITS ON REASONABLE CHARGES.

(a) PROCEDURES FOR ESTABLISHMENT OF SPECIAL LIMITS ON REASONABLE CHARGES FOR PART B SERVICES.—Section 1842(bX8) of the Social Security Act (42 U.S.C. 1395u(bX8)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by inserting "(A)" after "(8)"; and

(3) by adding at the end the following new subparagraphs:

"(BXi) The Secretary may provide for an increase or decrease in the reasonable charge otherwise recognized under this section with respect to a specific physicians' service only in accordance with the

criteria set forth in subparagraph (A) and with the succeeding provisions of this paragraph.

"(ii) The factors described pursuant to subparagraph (A)(i) with respect to payment for physicians' services shall include, but need not be limited to, the following:

"(I) Prevailing charges for a service in a particular locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing the services in the different localities.

"(II) The programs established under this title and title XIX are the sole or primary sources of payment for a service.

"(III) The marketplace for a service is not truly competitive because of a limited number of physicians who perform that service.

"(IV) There have been increases in charges for a service that cannot be explained by inflation or technology.

"(V) The charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

"(VI) The prevailing charges for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

"(iii) In applying subparagraph (A), the Secretary may compare—

"(I) the charges and resource costs for related procedures,

"(II) charges and resource costs for the procedure over a period of time,

"(III) charges for a procedure in different geographic areas, and

"(IV) the charges and allowed payments for a procedure under this part and by other payors.

"(iv) The factors considered under subparagraph (A)(ii) shall take into account regional differences in fees, unless there is substantial economic justification for a uniform fee or a uniform payment limit. Such substantial economic justification must be explained by the Secretary in the notice and final determination required by paragraph (9).

"(v) An adjustment under clause (i) on the basis of a comparison of the prevailing charges in different localities may be made only if the Secretary determines that the prevailing charge allowed in one locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs.

"(vi) In this subparagraph, 'resource costs' include factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

"(C) In determining whether to adjust payment rates under subparagraph (B)(i), the Secretary shall consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.".

(b) INHERENT REASONABLENESS PROCEDURES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by redesig-

nating paragraph (9) as paragraph (11) and inserting after paragraph (8) the following new paragraphs:

"(9)(A) In the case of any physicians' service with respect to which the Secretary—

"(i) determines, after appropriate consultation with representatives of the physicians likely to be affected by any change in the reasonable charge, that the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

"(ii) proposes to establish a reasonable charge that is realistic and equitable or a methodology for arriving at such a charge, the Secretary shall publish notice of such proposal in the Federal Register.

"(B) A notice required by subparagraph (A) shall—

"(i) specify the charge or methodology proposed to be established with respect to a service and shall explain the factors and data that the Secretary took into account in determining the charge or methodology so specified, and

"(ii) explain the potential impacts described in paragraph (8)(C).

"(C) After publication of the notice required by subparagraph (A), the Secretary shall allow not less than 60 days for public comment on the proposal.

"(D) In addition to carrying out its functions under section 1845, the Physician Payment Review Commission (in this paragraph referred to as the 'Commission') shall comment on any such proposal within the period of comment allowed by the Secretary pursuant to subparagraph (C).

"(E)(i) Taking into consideration the comments made by the Commission and the public, the Secretary shall publish in the Federal Register a final determination with respect to the reasonable charge or methodology to be established with respect to the service.

"(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination, and shall include and respond to the comments made by the Commission pursuant to subparagraph (D).

"(10)(A)(i) If an adjustment under paragraph (8)(B) results in a reduction in the reasonable charge for a physicians' service, and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of such reduction and before the end of the period described in subparagraph (C), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) 1/2 of the amount by which the physician's actual charge for the service for the previous 12-month period exceeds the limiting charge.

"(ii) In clause (i), the term 'limiting charge' means, with respect to a service, 125 percent of the inherently reasonable charge established under paragraph (8).

"(B) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(C) Subparagraph (A) shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(c) REVIEW OF PROCEDURES.—Not later than October 1, 1987, the Secretary of Health and Human Services shall review the inherent reasonableness of the reasonable charges for at least 10 of the most costly procedures with respect to which payment is made under part B of title XVIII of the Social Security Act (determined on the basis of the aggregate annual payments under such part with respect to each such procedure).

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 9334. PAYMENT FOR CATARACT SURGICAL PROCEDURES.

(a) LIMITATIONS.—Section 1842(b)(11) of the Social Security Act (42 U.S.C. 1395u(b)(11)), as redesignated by section 9333(b), is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(2) by inserting "(A)" after "(11)", and

(3) by adding at the end the following new subparagraphs:

"(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987 and shall be further reduced by 2 percent with respect to procedures performed in 1988. A reduced prevailing charge under this subparagraph shall become the prevailing charge level for subsequent years for purposes of applying the economic index under the fourth sentence of paragraph (3).

"(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

"(C)(i) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (B), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of such reduction (subject to clause (iv)), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician's actual charges for the service for the previous 12-month period exceeds the limiting charge.

"(ii) In clause (i), the term 'limiting charge' means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in clause (i).

"(iii) If a physician knowingly and willfully imposes charges in violation of clause (i), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(iv) This subparagraph shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(b) RATIFICATION OF REGULATIONS.—

(1) IN GENERAL.—The Congress hereby ratifies the final regulation of the Secretary of Health and Human Services published on page 35693 of volume 51 of the Federal Register on October 7, 1986, relating to reasonable charge payment limits for anesthesia services under the medicare program.

(2) PATIENT PROTECTIONS.—In the case of any reduction in the reasonable charge for physicians' services effected under the regulation described in paragraph (1), the provisions of section 1842(b)(10) of the Social Security Act (added by the amendment made by subsection (a)(3)) shall apply in the same manner and to the same extent as they apply to a reduction in the reasonable charge for a physicians' service effected under section 1842(b)(8) of such Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1987.

SEC. 9335. PAYMENT RATES FOR RENAL SERVICES AND IMPROVEMENTS IN ADMINISTRATION OF END STAGE RENAL DISEASE NETWORKS AND PROGRAM.

(a) COMPOSITE RATES FOR DIALYSIS SERVICES.—

(1) IN GENERAL.—Effective with respect to dialysis services provided on or after October 1, 1986, and before October 1, 1988, the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a free-standing facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act at a level equal to the respective rate in effect as of May 13, 1986, reduced by $2.00.

(2) ASSURING PROMPT CONSIDERATION OF EXCEPTION REQUESTS.—Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended—

(A) in the third sentence, by inserting "and of pediatric facilities" after "isolated, rural areas", and

(B) by inserting after the third sentence the following new sentence: "Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed.".

(3) EFFECTIVE DATE.—The amendments made by paragraph (2) shall apply to applications filed on or after the date of the enactment of this Act.

(b) REPORT ON PAYMENT RATES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide for—

(A) a study to evaluate the effects of reductions in the rates of payment for facility and physicians' services under the medicare program for patients with end stage renal disease on their access to care or on the quality of care, and

(B) a report to Congress on the results of the study by not later than January 1, 1988.

(2) ARRANGEMENTS WITH INSTITUTE OF MEDICINE.—The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in paragraph (1). If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(c) COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking "and" at the end of subparagraph (H)(ii),

(B) by inserting "and" at the end of subparagraph (I), and

(C) by inserting after subparagraph (I) the following new subparagraph:

"(J) immunosuppressive drugs furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant procedure;".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to immunosuppressive drugs furnished on or after January 1, 1987.

(d) REORGANIZATION OF ESRD NETWORK AREAS AND ORGANIZATIONS.—

(1) IN GENERAL.—Subparagraph (A) of subsection (c)(1) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended to read as follows:

"(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

"(I) establish at least 17 end stage renal disease network areas, and

"(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

"(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

"(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.".

(2) DEADLINE FOR ESTABLISHING NEW AREAS.—The Secretary of Health and Human Services shall establish end stage renal disease network areas, pursuant to the amendment made by paragraph (1), not later than May 1, 1987. The Secretary shall establish network administrative organizations for such areas by not later than July 1, 1987.

(3) TRANSITION.—If, under the amendment made by paragraph (1), the Secretary designates a network administrative organization for an area which was not previously designated for that area, the Secretary shall offer to continue to fund the previously designated organization for that area for a period of 30 days after the first date the newly designated organization assumes the duties of a network administrative organization for that area.

(e) PATIENT REPRESENTATION ON COUNCILS AND MEDICAL REVIEW BOARDS.—Subparagraph (B) of subsection (c)(1) of section 1881 of the Social Security Act is amended to read as follows:

"(B) At least one patient representative shall serve as a member of each network council and each medical review board.".

(f) RESPONSIBILTIES OF NETWORK ORGANIZATIONS.—Subsection (c)(2) of section 1881 of such Act is amended—

(1) in subparagraph (A), by inserting before the semicolon the following: "and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs";

(2) in subparagraph (B), by inserting before the first semicolon the following: "and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs";

(3) in subparagraph (D), by inserting before the semicolon the following: "and reporting to the Secretary on facilities and providers that are not providing appropriate medical care";

(4) in subparagraph (E), by inserting "and encouraging participation in vocational rehabilitation programs" after "self-care settings and transplantation"; and

(5) by redesignating subparagraphs (D) and (E) as subparagraphs (G) and (H), respectively, and inserting after subparagraph (C) the following new subparagraphs:

"(D) implementing a procedure for evaluating and resolving patient grievances;

"(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

"(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and subsection (g) and to assure the maintenance of the registry established under paragraph (7);".

(g) FACILITY COOPERATION WITH NETWORKS.—The first sentence of subsection (c)(3) of section 1881 of such Act is amended by inserting "or to follow the recommendations of the medical review board" after "consistently failed to cooperate with network plans and goals".

(h) INTENT OF CONGRESS RESPECTING MAXIMUM USE OF VOCATIONAL REHABILITATION SERVICES.—The first sentence of subsection (c)(6) of section 1881 of such Act is amended by inserting before the period the following: "and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment".

(i) NATIONAL END STAGE RENAL DISEASE REGISTRY.—

(1) ESTABLISHMENT OF REGISTRY.—Subsection (c) of section 1881 of such Act is further amended by adding at the end the following new paragraph:

"(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

"(A) the preparation of the annual report to the Congress required under subsection (g);

"(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

"(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

"(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

"(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to

assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.".

(2) REPORT.—The Secretary of Health and Human Services shall submit to the Congress, no later than April 1, 1987, a full report on the progress made in establishing the national end stage renal disease registry under the amendment made by paragraph (1) and shall establish such registry by not later than January 1, 1988.

(j) FUNDING OF ESRD NETWORK ORGANIZATIONS.—

(1) IN GENERAL.—Subsection (b)(7) of section 1881 of the Social Security Act is amended by adding at the end the following new sentence: "The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to treatment furnished on or after January 1, 1987.

(k) PROTOCOLS ON REUSE OF DIALYSIS FILTERS AND OTHER DIALYSIS SUPPLIES.—

(1) ESTABLISHMENT OF PROTOCOLS.—Paragraph (7) of subsection (f) of section 1881 of the Social Security Act is amended to read as follows:

"(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

"(B) With respect to dialysis services furnished on or after January 1, 1988, no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

"(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.".

(2) DEADLINE.—The Secretary of Health and Human Services shall establish the protocols described in section 1881(f)(7)(A) of the Social Security Act by not later than October 1, 1987.

(l) EFFECTIVE DATE FOR CERTAIN AMENDMENTS.—The amendments made by subsections (e), (f), and (g) shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1).

SEC. 9336. VISION CARE.

(a) DEFINING SERVICES AN OPTOMETRIST CAN PROVIDE.—Clause (4) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) is

amended to read as follows: "(4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1987.

SEC. 9337. OCCUPATIONAL THERAPY SERVICES.

(a) COVERAGE.—Subparagraph (C) of section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended to read as follows:

"(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g)),".

(b) LIMITATION ON PAYMENTS.—Section 1833(g) of such Act (42 U.S.C. 1395l(g)) is amended—

(1) by striking "next to last sentence" and inserting "second sentence", and

(2) by adding at the end thereof the following new sentence: "In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).".

(c) CERTIFICATION STANDARD.—(1) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)(C)) is amended—

(A) by inserting "or outpatient occupational therapy services" after "outpatient physical therapy services",

(B) in clause (i), by inserting "or occupational therapy services, respectively," after "physical therapy services", and

(C) in clause (ii), by inserting "or qualified occupational therapist, respectively," after "qualified physical therapist".

(2) The second sentence of section 1835(a) of such Act and section 1866(e) of such Act (42 U.S.C. 1395n(a), 1395cc(e)) are each amended—

(A) by inserting "(or meets the requirements of such section through the operation of section 1861(g))" after "1861(p)(4)(A)" and after "1861(p)(4)(B)", and

(B) by inserting "or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

(d) DEFINITION AND INCLUSION WITH OTHER PART B SERVICES.—(1) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by inserting after subsection (f) the following new subsection:

"OUTPATIENT OCCUPATIONAL THERAPY SERVICES

"(g) The term 'outpatient occupational therapy services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that 'occupational' shall be substituted for 'physical' each place it appears therein.".

(2) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting "and outpatient occupational therapy services" after "outpatient physical therapy services".

(3) Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting "(including through the operation of section 1861(g))" after "section 1861(p)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987.

SEC. 9338. SERVICES OF A PHYSICIAN ASSISTANT.

(a) SERVICES COVERED.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 9335(c)(1) of this subtitle, is amended—

(1) by striking "and" at the end of subparagraph (I),

(2) by adding "and" at the end of subparagraph (J), and

(3) by adding at the end the following new subparagraph:

"(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(3)) under the supervision of a physician (as so defined) in a hospital, skilled nursing facility, or intermediate care facility (as defined in section 1905(c)) or as an assistant at surgery and which the physician assistant is legally authorized to perform by the State in which the services are performed, and

"(ii) such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;".

(b) DETERMINATION OF PAYMENT AMOUNT.—Section 1842(b) of such Act (42 U.S.C. 1395u(b)), as amended by section 9333(b), is amended by adding at the end the following new paragraph:

"(12)(A) With respect to services described in section 1861(s)(2)(K) (relating to a physician assistant acting under the supervision of a physician)—

"(i) payment under this part may only be made on an assignment-related basis; and

(ii) the prevailing charges determined under paragraph (3) shall not exceed—

"(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

"(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services performed by physicians who are not specialists.

"(B) In subparagraph (A)(ii)(II), the term 'applicable percentage' means—

"(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

"(ii) 85 percent in the case of other services.

"(C) Except for deductible and coinsurance amounts applicable under section 1833, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this

part a bill or request for payment for services described in section 1861(s)(2)(K) in violation of subparagraph (A)(i) is subject to a civil monetary penalty of not to exceed $2,000 for each such bill or request. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.".

(c) PAYMENT TO EMPLOYER.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(1) by striking "except that payment may be made (A)(i)" and inserting "except that (A) payment may be made (i)";

(2) by striking "or (B)" and by inserting "(B) payment may be made"; and

(3) by inserting before the period at the end the following: ", and (C) in the case of services described in section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant involved".

(d) REDUCTION IN PAYMENT TO AVOID DUPLICATE PAYMENT.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may reduce the amount of payments otherwise made to hospitals and skilled nursing facilities under title XVIII of the Social Security Act, so as to eliminate estimated duplicate payments for historical or current costs attributable to services described in section 1861(s)(2)(K) of such Act (for which payment may be made under the amendments made by this section).

(e) STUDY OF PAYMENT RATES.—The Secretary shall report to Congress, by not later than April 1, 1988, concerning adjustments to the amount of payment made, under part B of title XVIII of the Social Security Act, for services described in section 1861(s)(2)(K) of such Act, to ensure that the amount of such payments reflects the approximate cost of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1987.

SEC. 9339. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) TREATMENT OF HOSPITAL OUTPATIENT LABORATORIES.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(A) in paragraph (1)(B), by striking "hospital laboratory" and inserting "qualified hospital laboratory (as defined in subparagraph (D))";

(B) in paragraph (1)(C)—

(i) in the first sentence, by striking "hospital laboratory" and inserting "qualified hospital laboratory (as defined in subparagraph (D))", and by striking ", and ending on December 31, 1987", and

(ii) by striking the second sentence;

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(D) In this subsection, the term 'qualified hospital laboratory' means a hospital laboratory which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergen-

cy room which is available to provide services 24 hours a day and 7 days a week."; and

(D) in paragraph (2), by striking "hospital laboratory" and inserting "qualified hospital laboratory (as defined in paragraph (1)(D))".

(2) EFFECTIVE DATE.—The amendments made by this subsection apply to clinical diagnostic laboratory tests performed on or after January 1, 1987.

(b) DELAYING FOR 2 YEARS REQUIREMENT OF NATIONAL FEE SCHEDULE.—

(1) IN GENERAL.—Section 1833(h)(1)(B) of such Act is amended by striking "1987" and "1988" and inserting "1989" and "1990", respectively.

(2) CONFORMING AMENDMENT.—Section 1833(h)(2) of such Act is amended by striking "(or, effective January 1, 1988, for the United States)".

(3) REPORT.—The Secretary of Health and Human Services shall report to Congress, by not later than April 1, 1988, on the advisability and feasibility of, and methodology for, establishing national fee schedules for payment for clinical diagnostic laboratory tests under section 1833(h) of the Social Security Act.

(c) PAYMENT FOR TIME AND TRAVEL COSTS TO COLLECT SAMPLES FROM CERTAIN IMMOBILE BENEFICIARIES.—

(1) IN GENERAL.—Section 1833(h)(3) of such Act is amended—

(A) by inserting "(A)" after "provide for and establish", and

(B) by inserting before the period at the end the following: ", and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital)".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to samples collected on or after January 1, 1987.

(d) STATE STANDARDS FOR DIRECTORS OF CLINICAL LABORATORIES.—

(1) IN GENERAL.—If a State (as defined for purposes of title XVIII of the Social Security Act) provides for the licensing or other standards with respect to the operation of clinical laboratories (including such laboratories in hospitals) in the State under which such a laboratory may be directed by an individual with certain qualifications, nothing in such title shall be construed as authorizing the Secretary of Health and Human Services to require such a laboratory, as a condition of payment or participation under such title, to be directed by an individual with other qualifications.

(2) EFFECTIVE DATE.—Paragraph (1) shall take effect on January 1, 1987.

(e) EXTENSION OF MORATORIUM ON LABORATORY PAYMENT DEMONSTRATION.—Section 9204(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "January 1, 1987" and inserting "January 1, 1988".

SEC. 9340. PAYMENT FOR PARENTERAL AND ENTERAL NUTRITION SUPPLIES AND EQUIPMENT.

The Secretary of Health and Human Services shall apply the sixth sentence of section 1842(b)(3) of the Social Security Act to payment—

(1) for enteral nutrition nutrients, supplies, and equipment and parenteral nutrition supplies and equipment furnished on or after January 1, 1987, and

(2) for parenteral nutrition nutrients furnished on or after October 1, 1987.

SEC. 9341. CHANGING MEDICARE APPEAL RIGHTS.

(a) REVIEW OF PART B DETERMINATIONS.—(1) Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended—

(A) by inserting "or part B" in subsection (a) after "amount of benefits under part A",

(B) by inserting "or part B" in subsection (b)(1)(C) after "part A",

(C) by amending paragraph (2) of subsection (b) to read as follows:

"(2) Notwithstanding paragraph (1)(C), in the case of a claim arising—

"(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or

"(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.", and

(D) by adding at the end the following new paragraphs:

"(3) Review of any national coverage determination under section 1862(a)(1) respecting whether or not a particular type or class of items or services is covered under this title shall be subject to the following limitations:

"(A) Such a determination shall not be reviewed by any administrative law judge.

"(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of chapter 5 of title 5, United States Code, or section 1871(b), relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

"(C) In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it shall remand the matter to the Secretary for additional proceedings to supplement the record and the court may not determine that an item

or service is covered except upon review of the supplemented record.

"(4) A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.".

(2) Section 1842(b)(3)(C) of such Act (42 U.S.C. 1395u(b)(3)(C)) is amended by striking "$100 or more" and inserting "at least $100, but not more than $500".

(3) Section 1879(d) of such Act (42 U.S.C. 1395pp(d)) is amended by striking "section 1869(b)" and all that follows through "part B)" and inserting "sections 1869(b) and 1842(b)(3)(C) (as may be applicable)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1987.

SEC. 9342. ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct at least 5 (and not more than 10) demonstration projects to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services for individuals entitled to benefits under title XVIII of the Social Security Act (in this section referred to as "medicare beneficiaries") who are victims of Alzheimer's disease or related disorders.

(b) SERVICES UNDER DEMONSTRATION PROJECTS.—The services provided under demonstration projects must be designed to meet the specific needs of Alzheimer's disease patients and may include—

(1) case management services,

(2) home and community-based services,

(3) mental health services,

(4) outpatient drug therapy,

(5) respite care and other supportive services and counseling for family,

(6) adult day care services, and

(7) other in-home services.

(c) CONDUCT OF PROJECTS.—The demonstration projects shall—

(1) each be conducted over a period of 3 years;

(2) provide each medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge,

(3) be conducted by an entity which either directly or by contract is able to provide such comprehensive evaluations and the additional services (described in subsection (b)) covered by the project;

(4) be conducted in sites which are chosen so as to be geographically diverse and located in States with a high proportion of medicare beneficiaries and in areas readily accessible to a significant number of medicare beneficiaries; and

(5) involve community outreach efforts at each site to enroll the maximum number of medicare beneficiaries in each project.

(d) EVALUATION AND REPORTS.—The Secretary shall provide for an evaluation of the demonstration projects and shall submit to the

Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate—

(1) a preliminary report during the third year of the projects, which report shall include a description of the sites at which the projects are being conducted and the services being provided at the different sites, and

(2) a final report upon completion of the projects, which report shall include recommendations for appropriate legislative changes.

(f) FUNDING.—Expenditures (not to exceed $40,000,000 for the projects and $2,000,000 for the evaluation of the projects) made for the demonstration projects shall be made from the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration projects.

SEC. 9343. PAYMENTS FOR AMBULATORY SURGERY.

(a) AMOUNTS PAYABLE; ANNUAL UPDATING.—

(1)(A) Section 1833(a)(4) of the Social Security Act (42 U.S.C. 1395l(a)(4)) is amended to read as follows:

"(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i).".

(B) Section 1833(i) of such Act (42 U.S.C. 1395l(i)) is amended by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively, and inserting after paragraph (2) the following new paragraph:

"(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services furnished in connection with surgical procedures specified under paragraph (1)(A) in a cost reporting period shall be equal to the lesser of—

"(i) the amount determined with respect to such services under subsection (a)(2)(B); or

"(ii) the blend amount (described in subparagraph (B)).

"(B)(i) The blend amount for a cost reporting period is the sum of—

"(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

"(II) the ASC proportion (as defined in clause (ii)(II)) of 80 percent of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A).

"(ii) In this paragraph:

"(I) The term 'cost proportion' means 75 percent for cost reporting periods beginning in fiscal year 1988, and 50 percent for other cost reporting periods.

"(II) The term 'ASC proportion' means 25 percent for cost reporting periods beginning in fiscal year 1988, and 50 percent for other cost reporting periods.".

(2) CONFORMING AMENDMENT.—Section 1833(b)(3) of such Act is amended by striking "or (i)(4)" and inserting in lieu thereof "or (i)(5)".

(b) UPDATING ASC RATES—

(1) RATE UPDATE.—Subparagraphs (A) and (B) of section 1833(i)(2) of such Act are each amended by striking "shall be reviewed periodically" and inserting in lieu thereof "shall be reviewed and updated not later than July 1, 1987, and annually thereafter".

(2) ASC LIST UPDATE.—Section 1833(i)(1) of such Act is amended by adding at the end (after and below subparagraph (B)) the following:

"The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years.".

(c) PREVENTING UNBUNDLING OF HOSPITAL OUTPATIENT SERVICES.—

(1) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "inpatient" and inserting "patient".

(2) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(A) by striking "inpatient hospital", and

(B) by striking "an inpatient" and inserting "a patient".

(3) Section 1866 of such Act (42 U.S.C. 1395cc) is further amended by adding at the end the following new subsection:

"(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service for which payment may be made under part B and such bill or request violates an arrangement under subsection (a)(1)(H), is subject to a civil monetary penalty of not to exceed $2,000. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.".

(d) PRO REVIEW.—

(1) Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c-3(a)(1)) is amended by inserting "and subject to the requirements of subsection (d)" after "subject to the terms of the contract".

(2) Section 1154 of such Act is amended by adding at the end the following new subsection:

"(d) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary (and except as provided in section 1164(b)(4)) a sample of such procedures.".

(e) COINSURANCE AND DEDUCTIBLE TO APPLY WITHOUT REGARD TO SETTING OF AMBULATORY SURGERY.—

(1) Clauses (i) and (ii) of section 1832(a)(2)(F) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)) are each amended by inserting "standard overhead" before "amount".

(2)(A) Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended by striking paragraph (3) and redesignating paragraphs (4) and (5) as paragraphs (3) and (4).

(B) Subparagraphs (A) and (B) of section 1833(i)(2) of such Act are each amended by inserting "80 percent of" before "a standard overhead amount".

(f) DEVELOPMENT OF PROSPECTIVE PAYMENT METHODOLOGY FOR OUTPATIENT HOSPITAL SERVICES.—Section 1135 of the Social Security Act (42 U.S.C. 1320b–5) is amended by adding at the end the following new subsection:

"(d)(1) The Secretary shall develop a fully prospective payment system for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis.

"(2) The system shall, to the extent practicable, provide for an all-inclusive payment rate for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis, which rate encompasses payment for facility services and all medical and other health services, other than physicians' services, commonly furnished in connection with such procedures.

"(3) The system shall provide for appropriate payment rates with respect to such procedures.

"(4) Such rates shall take into account at least the following considerations:

"(A) The costs of hospitals providing ambulatory surgical procedures.

"(B) The costs under this title of payment for such procedures performed in ambulatory surgical centers.

"(C) The extent to which any differences in such costs are justifiable.

"(5) The Secretary shall submit to Congress—

"(A) an interim report on the development of the system by April 1, 1988, and

"(B) a final report on such system by April 1, 1989.

The report under subparagraph (B) shall include recommendations concerning the implementation of the payment system for ambulatory surgical procedures performed on or after October 1, 1989.

"(6)(A) The Secretary shall develop a model system for the payment for outpatient hospital services other than ambulatory surgery.

"(B) The Secretary shall submit to Congress a report on the model payment system under subparagraph (A) by January 1, 1991.".

(g) REPORTING OF OPD SERVICES USING HCPCS.—Not later than July 1, 1987, each fiscal intermediary which processes claims under part B of title XVIII of the Social Security Act shall require hospitals, as a condition of payment for outpatient hospital services under that part, to report claims for payment for such services under such part using a HCFA Common Procedure Coding System.

(h) EFFECTIVE DATES.—

(1) The amendments made by subsection (a)(1) shall apply to cost reporting periods beginning on or after October 1, 1987.

(2) The amendments made by subsections (b)(1) and (d) shall apply to services furnished after June 30, 1987.

(3) The Secretary of Health and Human Services shall first provide, under the amendment made by subsection (b)(2), for the review and update of procedure lists within 6 months after the date of the enactment of this Act.

(4) The amendments made by subsection (c) shall apply to contracts entered into or renewed after January 1, 1987.

SEC. 9344. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B.

(a) ADDITIONAL MEMBERS FOR PHYSICIAN PAYMENT REVIEW COMMISSION.—

(1) 2 ADDITIONAL MEMBERS.—Section 1845(a)(2) of the Social Security Act (42 U.S.C. 1395w-1(a)(2)) is amended by striking "11 individuals" and inserting "13 individuals".

(2) APPOINTMENT OF ADDITIONAL MEMBERS.—The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Physician Payment Review Commission, as required by the amendment made by paragraph (1), no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than five members expire in any one year.

(b) EFFECTIVE DATE OF VOLUNTARY DISENROLLMENT FROM MEDICARE.—

(1) IN GENERAL.—The second and sixth sentences of section 1838(b) of the Social Security Act (42 U.S.C. 1395p(b)) are each amended by striking "calendar quarter following the calendar quarter" and inserting "month following the month".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to notices filed on or after July 1, 1987.

(c) STUDY ON PROSPECTIVE PAYMENT OF RADIOLOGY, ANESTHESIA, AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS.—The Secretary of Health and Human Services shall study and report to Congress by July 1, 1987, concerning the design and implementation of a prospective payment system for payment, under part B of title XVIII of the Social Security, for radiology, anesthesia, and pathology services furnished to hospital inpatients. Such report shall include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

(d) PREVENTIVE HEALTH SERVICES DEMONSTRATION PROGRAM.—Effective as if included in section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 when such section was enacted, such section is amended—

(1) in subsection (c)(2), by inserting "(at least one of which shall serve a rural area)" after "five sites", and

(2) by striking the last sentence of subsection (f) and inserting the following: "Funding for the administrative costs of the demonstration program shall not exceed $5,900,000 over the duration of the program.".

PART 4—IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

SEC. 9351. PRO REVIEW OF HOSPITAL DENIAL NOTICES.

(a) IN GENERAL.—Section 1154 of the Social Security Act (42 U.S.C. 1320c–3), as amended by section 9343(d)(2) of this subtitle, is amended by adding at the end the following new subsection:

"(e)(1) If—

"(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

"(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

"(2) If—

"(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

"(B) the attending physician has not agreed with the hospital's determination,

the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital's determination.

"(3)(A) If a patient (or a patient's representative)—

"(i) has received a notice under paragraph (1), and

"(ii) requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital's determination and shall provide notice (by telephone and in writing) to the patient or representative and the hospital and attending physician involved of the results of the review. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or whether or not the patient will be liable for payment for such continued care.

"(B) If a patient (or a patient's representative) requests a review under subparagraph (A) while the patient is still an inpatient in the hospital and not later than noon of the first working day after the date the patient receives the notice under paragraph (1), then—

"(i) the hospital shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

"(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

"(4) If—

"(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date the patient (or patient's representative) receives the notice under paragraph (1), and

"(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the hospital may not charge the patient for inpatient hospital services furnished before noon of the day after the date the patient or

representative receives notice of the peer review organization's decision.

"(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative)."

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after the date of the enactment of this Act.

(2) Section 1154(e)(4) of the Social Security Act (as added by the amendment made by subsection (a)) shall take effect on the date of the enactment of this Act.

SEC. 9352. PRO REVIEW OF INPATIENT HOSPITAL SERVICES AND EARLY READMISSION CASES.

(a) TIMELY PROVISION OF HOSPITAL INFORMATION.—(1) Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended by adding at the end the following new subsection:

"(g) The Secretary shall provide that fiscal intermediaries furnish to peer review organizations, each month on a timely basis, data necessary to initiate the review process under section 1154(a) on a timely basis. If the Secretary determines that a fiscal intermediary is unable to furnish such data on a timely basis, the Secretary shall require the hospital to do so.".

(2) Section 1816(a) of such Act (42 U.S.C. 1395h(a)) is amended by adding at the end the following: "As used in this title and part B of title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section.".

(b) REQUIRING REVIEW OF EARLY READMISSION CASES.—Section 1154(a) of such Act (42 U.S.C. 1320c–3(a)), as amended by section 9401(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

"(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an 'early readmission case' is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge."

(c) EFFECTIVE DATES.—(1) The Secretary of Health and Human Services shall implement the amendment made by subsection (a) not later than 6 months after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to contracts entered into or renewed on or after January 1, 1987, except that in applying such amendment before January 1, 1989, the term "post-hospital services" does not include physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

SEC. 9353. PRO REVIEW OF QUALITY OF CARE.

(a) REQUIRING PRO REVIEW OF QUALITY OF CARE.—

(1) ALLOCATION OF FUNDS FOR QUALITY CARE REVIEW.—Section 1154(a)(4) of the Social Security Act (42 U.S.C. 1320c-3(a)(4)) is amended by adding at the end the following: "Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.".

(2) REQUIRING REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Such section is further amended—

(A) by inserting "(A)" after "(4)";

(B) by adding at the end the following new subparagraph:

"(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a contract under section 1876 for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. The previous sentence shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C).";

(C) by adding at the end of such subparagraph the following: "Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization."; and

(D) by adding at the end the following additional new subparagraph:

"(C) The Secretary may provide, by contract under competitive procurement procedures on a State-by-State basis in up to 25 States, for the review described in subparagraph (B) by an appropriate entity (which may be a peer review organization described in that subparagraph). In selecting among States in which to conduct such competitive procurement procedures, the Secretary may not select States which, as a group, have more than 50 percent of the total number of individuals enrolled with eligible organizations under section 1876. Under a contract with an entity under this subparagraph—

"(i) the entity must be, or must meet all the requirements under section 1152 to be, a utilization and quality control peer review organization,

"(ii) the contract must meet the requirement of section 1153(b)(3), and

"(iii) the level of effort expended under the contract shall be, to the extent practicable, not less than the level of effort that would otherwise be required under the third sentence of subparagraph (B) if this subparagraph did not apply.".

(3) IDENTIFICATION OF METHODS FOR IDENTIFYING CASES OF SUBSTANDARD CARE.—Section 1154 of such Act (42 U.S.C. 1320c-3), as amended by sections 9343(d)(2) and 9351(a), is amended by adding at the end the following new subsection:

"(f) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care."

(4) SMALL-AREA ANALYSIS.—The Secretary of Health and Human Services shall provide, to at least 12 utilization and quality control peer review organizations with contracts under part B of title XI of the Social Security Act, data and data processing assistance to allow each of these organizations to review and analyze small-area variations, in the service area of the organization, in the utilization of hospital and other health care services for which payment is made under title XVIII of such Act.

(5) CONFORMING AMENDMENT.—Section 9405 of the Consolidated Omnibus Budget Reconciliation Act of 1986 is amended by striking "January" and inserting "April".

(6) EFFECTIVE DATES.—(A)(i) Except as provided in clause (ii), the amendments made by paragraphs (1) and (2)(D) shall apply to contracts as of January 1, 1987.

(ii) The amendment made by paragraph (1) shall not be construed as requiring, before January 1, 1989, the review of physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

(B) The amendment made by paragraph (2)(B) shall apply to contracts as of April 1, 1987.

(C) The amendment made by paragraph (2)(C) shall apply to review activities conducted by organizations on or after January 1, 1988.

(D) The amendment made by the paragraph (3) becomes effective on the date of the enactment of this Act.

(b) REQUIRING CONSUMER REPRESENTATIVE ON PEER REVIEW BOARDS.—

(1) IN GENERAL.—Section 1152 of such Act (42 U.S.C. 1320c-1) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by adding at the end the following new paragraph:

"(3) has at least one individual who is a representative of consumers on its governing body."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts entered into or renewed on or after January 1, 1987.

(c) IMPROVING PEER REVIEW RESPONSIVENESS TO BENEFICIARY COMPLAINTS.—

(1) APPROPRIATE REVIEW OF COMPLAINTS REQUIRED.—Section 1154(a) of such Act (42 U.S.C. 1320c–3(a)), as amended by section 9352(b), is further amended by adding at the end the following new paragraph:

"(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to complaints received on or after the first day of the first month that begins more than 9 months after the date of the enactment of this Act.

(d) SHARING OF INFORMATION BY PEER REVIEW ORGANIZATIONS.—

(1) IN GENERAL.—Subparagraph (C) of section 1160(b)(1) of such Act (42 U.S.C. 1320c–9(b)(1)) is amended to read as follows:

"(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body in carry out its respective function which is within the jurisidiction of the agency or body under State law or under section 1865;".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to requests for data and information made on and after the end of the 6-month period beginning on the date of the enactment of this Act.

(e) FUNDING OF ADDITIONAL PRO ACTIVITIES.—

(1) THROUGH AGREEMENTS WITH HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.—Section 1866(a) of such Act (42 U.S.C. 1395cc(a)) is amended—

(A) in paragraph (1)(F)—

(i) by redesignating clauses (i), (ii), and (iii), as subclauses (I), (II), and (III), respectively,

(ii) by inserting "(i)" after "(F)", and

(iii) by adding at the end the following new clause:

"(ii) in the case of hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (4)(A);"; and

(B) by adding at the end the following new paragraph:

"(4)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, facility, or agency involved, for which payment may be made under this title.

"(B) For purposes of payment under this title, the cost of such an agreement to the hospital, facility, or agency shall be considered a cost incurred by such hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, facility, or agency in accordance with a schedule established by the Secretary.

"(C) Such payments—

"(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

"(ii) shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of title XI.".

(2) THROUGH AGREEMENTS WITH HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)), as amended by section 9312(f) of this subtitle, is amended by adding at the end the following new paragraph:

"(7)(A) Except as provided under section 1154(a)(4)(C), each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) under which the peer review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

"(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

"(C) Such payments—

"(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

"(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.".

(3) EFFECTIVE DATE.—

(A) HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.—The amendments made by paragraph (1) shall apply to provider agreements as of October 1, 1987.

(B) HMO'S AND CMP'S.—The amendment made by paragraph (2) shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act, as of April 1, 1987.

MEDICAID

Subtitle E—Medicaid and Maternal and Child Health

TABLE OF CONTENTS OF SUBTITLE

PART 1—COVERAGE OF INDIVIDUALS

Sec. 9401. Optional coverage for poor pregnant women, infants, and children.
Sec. 9402. Optional coverage of elderly and disabled poor for all medicaid benefits.
Sec. 9403. Optional coverage of poor medicare beneficiaries for medicare cost-sharing expenses.
Sec. 9404. Medicaid eligibility for qualified severely impaired individuals.
Sec. 9405. Clarification of eligibility for qualified severely impaired individuals.
Sec. 9406. Payment for aliens under medicaid.
Sec. 9407. Optional presumptive eligibility period for pregnant women.
Sec. 9408. Respiratory care services for ventilator-dependent individuals.

PART 2—PROVISION OF SERVICES UNDER WAIVER AUTHORITY

Sec. 9411. Permitting States to offer home and community-based services to certain low-income individuals.
Sec. 9412. Waiver authority for chronically mentally ill and frail elderly.
Sec. 9413. Continuation of "Case-Managed Medical Care for Nursing Home Patients" demonstration project.
Sec. 9414. New Jersey respite care pilot project.
Sec. 9415. Inapplicability of Paperwork Reduction Act.

PART 3—PAYMENTS

Sec. 9421. Holding States harmless in fiscal year 1987 against a decrease in the federal medical assistance percentage.
Sec. 9422. Waiver of certain requirements.

PART 4—OTHER QUALITY AND EFFICIENCY MEASURES

Sec. 9431. Independent quality review of HMO services.

Sec. 9432. State utilization review systems.
Sec. 9433. Clarification of flexibility for State medicaid payment systems for disclosure requirements for inpatient services.
Sec. 9434. Financial disclosure requirements for HMOs; civil money penalties.
Sec. 9435. COBRA technical corrections and clarifications relating to the medicaid program.
Sec. 9436. Payment for certain long-term care patients in hospitals.

PART 5—MATERNAL AND CHILD HEALTH

Sec. 9441. Authorization and allotment of additional funds.
Sec. 9442. Maternal and child health and adoption clearinghouse.
Sec. 9443. Collection of data relating to adoption and foster care.

PART 1—COVERAGE OF INDIVIDUALS

SEC. 9401. OPTIONAL COVERAGE OF POOR PREGNANT WOMEN, INFANTS, AND CHILDREN.

(a) CREATION OF NEW OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by striking ", or" at the end of subclause (VII) and inserting a semicolon,

(2) by inserting "or" at the end of subclause (VIII), and

(3) by adding at the end the following new subclause:

"(IX) subject to subsection (l)(4), who are described in subsection (l)(1),".

(b) DESCRIPTION OF GROUP.—Section 1902 of such Act is amended by inserting after subsection (k) the following new subsection:

"(l)(1) Individuals described in this paragraph are—

"(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

"(B) infants under one year of age,

"(C) children who have attained one year of age but have not attained two years of age,

"(D) children who have attained two years of age but have not attained three years of age,

"(E) children who have attained three years of age but have not attained four years of age, and

"(F) children who have attained four years of age but have not yet attained five years of age,

who are not described in subsection (a)(10)(A)(i), whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

"(2) For purposes of paragraph (1), the State shall establish an income level which is a percentage (not more than 100 percent) of the nonfarm income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(IX)—

"(A) application of a resource standard shall be at the option of the State;

"(B) any resource standard or methodolgy that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodolgy that is applied under title XVI;

"(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), (D), (E), or (F) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of title IV;

"(D) the income standard to be applied is the income standard established under paragraph (2); and

"(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of title IV, and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

"(4) (A) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) unless the State has in effect, under its plan established under part A of title IV, payment levels that are not less than the payment levels in effect under its plan on April 17, 1986.

"(B)(i) A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover only individuals described in paragraph (1)(A) or to cover only individuals described in paragraph (1)(B).

"(ii) A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover individuals described in subparagraph (C), (D), (E), or (F) of paragraph (1) unless the State has elected, under such subsection, to cover individuals described in the preceding subparagraphs of such paragraph.".

(c) LIMITED BENEFITS FOR NEWLY ELIGIBLE PREGNANT WOMEN.—Section 1902 (a)(10) of such Act (42 U.S.C. 1396a (a)(10)) is amended, in the matter after subparagraph (D)—

"(1) by striking "and" before "(VI)", and (2) by inserting before the semicolon at the end the following: ", and (VII) the medical assistance made available to an individual described in subsection (1)(1)(A) who is eligible for medical assistance only assistance for services related to pregnancy (including prenatal, assistance for services related to pregnancy (including prenatel, delivery, and postpartum services) and to other conditions which may complicate pregnancy".

(d) CONTINUATION OF MEDICAL ASSISTANCE FOR CERTAIN PREGNANT WOMEN DURING PREGNANCY AND FOR CERTAIN INFANTS AND CHILDREN RECEIVING INPATIENT SERVICES.—Section 1902(e) of such Act (42 U.S.C. 1396(e)) is amended by adding at the end the following new paragraphs:

"(6) At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), the plan may provide that any woman described in such subsection and subsection (10)(1)(A) shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last day of her pregnancy.

"(7) If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in the case of an infant or child described in subparagraph (B), (C), (D), (E), or (F) of subsection (1)(I)—

"(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

"(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection, the infant or child shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) and subsection (1)(I) until the end of the stay for which the inpatient services are furnished.".

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(17) of such Act (42 U.S.C. 1396(a)(17)) is amended by inserting "except as provided in subsection (l)(3)," after "(17)".

(2) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "for any individual described in section 1902(a)(10)(A)(ii)(IX)" after "as medical assistance".

(f) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished in calendar quarters beginning on or after April 1, 1987.

(2)(A) Subparagraph (C) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1987.

(B) Subparagraph (D) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1988.

(C) Subparagraph (E) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1989.

(D) Subparagraph (F) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1990.

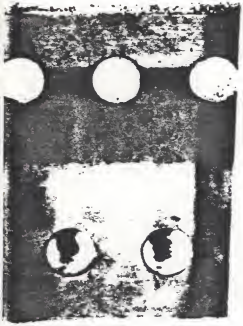
(3) An amendment made by this section shall become effective as provided in paragraph (1) or (2) without regard to whether or not final regulations to carry out such amendment have been promulgated by the applicable date.

SEC. 9402. OPTIONAL COVERAGE OF ELDERLY AND DISABLED POOR FOR ALL MEDICAID BENEFITS.

(a) CREATION OF NEW OPTIONAL CATEGORICALLY NEEDY GROUPS.—

(1) IN GENERAL.—Subsection (a)(10)(A)(ii) of section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 9401(a) of this subtitle, is amended—

(A) by striking "or" at the end of subclause (VIII),





(B) by striking the semicolon at the end of subclause (IX) and inserting, ", or", and

(C) by adding at the end the following new subclause:

"(X) subject to subsection (m)(3), who are described in subsection (m)(1);".

(2) DESCRIPTION OF INDIVIDUALS.—Section 1902 of such Act is further amended by adding after subsection (l), as added by section 9401(b) of this subtitle, the following new subsection:

"(m)(1) Individuals described in this paragraph are individuals—

"(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

"(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).".

(b) REQUIREMENT OF COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND OTHER SPECIAL RULES.—Section 1902(m) of such Act, as added by subsection (a)(2), is further amended by adding at the end the following new paragraphs:

"(3) A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X), unless the plan provides coverage of some or all of the individuals described in subsection (l)(1).

"(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

"(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

"(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this program for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regula-

icolon at the end of subclause (IX)
d
id the following new subclause:
section (m)(3), who are described in

DUALS.—Section 1902 of such Act is
after subsection (l), as added by sec-
the following new subsection:
n this paragraph are individuals—
ge or older or are disabled individ-
ction 1614(a)(3)),
ermined under section 1612 for pur-
security income program) does not
blished by the State consistent with

determined under section 1613 for
al security income program) do not
in paragraph (2)(B)) the maximum
n individual may have and obtain

blished under paragraph (1)(B) may
re than 100 percent) of the nonfarm
by the Office of Management and
n accordance with section 673(2) of
ation Act of 1981) applicable to a

at provides medical assistance to in-
section (a)(10)(A) and at the State's
paragraph (1)(C) such resource level
described in that paragraph) as may
individuals described in paragraph
ubsection (a)(10)(A).".
GE OF CERTAIN PREGNANT WOMEN
PECIAL RULES.—Section 1902(m) of
tion (a)(2), is further amended by
new paragraphs:
ovide coverage for individuals under
ss the plan provides coverage of some
ed in subsection (l)(1).
ion (a)(17), for individuals described
ed under the State plan by virtue of

d to be applied is the income stand-
(1)(B), and
in section 1612(b)(4)(B)(ii), costs in-
for any other type of remedial care
unt in determining income.
ed under this program for such indi-
subsection (a)(17), require or permit
duals.".
nendments made by this section shall
r calendar quarters beginning on or
gard to whether or not final regula-

tions to carry out such amendments have been promulgated by such date.

SEC. 9403. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR MEDICARE COST-SHARING EXPENSES.

(a) ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARY.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) by striking "and" at the end of subparagraph (C),

(2) by inserting "and" at the end of subparagraph (D), and

(3) by inserting after subparagraph (D) the following new subparagraph:

"(E) at the option of a State, but subject to subsection (m)(3), for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1),".

(b) QUALIFIED MEDICARE BENEFICIARY DEFINED.—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(p)(1) The term 'qualified medicare beneficiary' means an individual—

"(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818),

"(B) who, but for section 1902(a)(10)(E) and the election of the State, is not eligible for medical assistance under the plan,

"(C) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

"(D) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

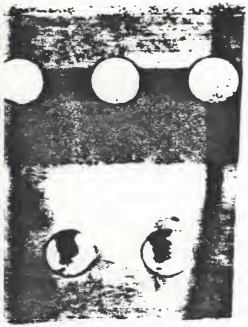
"(2)(A) The income level established under paragraph (1)(C) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).".

(c) LIMITED, MEDICARE GAP-FILLING BENEFITS.—Section 1902(a)(1) of such Act (42 U.S.C. 1395a(a)(10)), as amended by section 9401(c) of this subtitle and by subsection (a) of this section, is amended, in the matter after subparagraph (E)—

(1) by striking "and" before "(VII)", and

(2) by inserting before the semicolon at the end the following: ", and (VIII) the medical assistance made available to a quali-





fied medicare beneficiary described in section 1905(p)(1) shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b)".

(d) MEDICARE COST-SHARING DEFINED.—Section 1905(p) of such Act, as added by subsection (b), is amended by adding at the end the following:

"(3) The term 'medicare cost-sharing' means the following costs incurred with respect to a qualified medicare beneficiary:

"(A) Premiums under part B and (if applicable) under section 1818.

"(B) Deductibles and coinsurance described in section 1813.

"(C) The annual deductible described in section 1833(b).

"(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.".

(e) PAYMENT AMOUNTS.—Section 1902 of such Act, as amended by sections 9401(b) and 9402(a)(2) of this subtitle, is further amended by adding at the end the following new subsection:

"(n) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.".

(f) REQUIREMENT OF COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND OTHER SPECIAL RULES.—

(1) REQUIRING COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND INCOME STANDARD TO BE USED.—Section 1902(m) of such Act, as added by section 9402(a)(2) of this subtitle, and as amended by section 9402(b) of this subtitle, is amended—

(A) in paragraph (3), by inserting "or coverage under subsection (a)(10)(E)" after "subsection (a)(10)(A)(ii)(IX)", and

(B) by adding at the end of the following new paragraph:

"(5) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(p)(1)—

"(A) the income standard to be applied is the income standard described in section 1905(p)(1)(C), and

"(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.".

:cribed in section 1905(p)(1) shall be
ice for medicare cost-sharing (de-
subject to the provisions of subsec-

DEFINED.—Section 1905(p) of such
amended by adding at the end the

sharing' means the following costs
ed medicare beneficiary:
B and (if applicable) under section

surance described in section 1813.
e described in section 1833(b).
en the amount that is paid under
unt that would be paid under such
'80 percent' therein were deemed a

the option of a State, premiums for
re beneficiary with an eligible orga-

on 1902 of such Act, as amended by
this subtitle, is further amended by
new subsection:
ssistance furnished under this title
cting the furnishing of a service or
neficiary, the State plan may provide
spect to the service or item that re-
nt amount and any amount of pay-
ith respect to the service or item ex-
erwise payable under the State plan
le individuals who are not qualified

AGE OF CERTAIN PREGNANT WOMEN
CIAL RULES.—
OF CERTAIN PREGNANT WOMEN AND
NDARD TO BE USED.—Section 1902(m)
ection 9402(a)(2) of this subtitle, and
2(b) of this subtitle, is amended—
), by inserting "or coverage under
ter "subsection (a)(10)(A)(ii)(IX)", and
end of the following new paragraph:
ction (a)(17), for qualified medicare
on 1905(p)(1)—
d to be applied is the income stand-
05(p)(1)(C), and
in section 1612(b)(4)(B)(ii), costs in-
r for any other type of remedial care
ount in determining income.
led under this paragraph for such in-
f subsection (a)(17), require or permit
iduals.".

EFFECTIVE DATE OF BENEFITS.—Section 1902(e) of such act, as amended by section 9401(d) of this subtitle, is amended by adding at the end the following new paragraph:

"(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.".

(g) Conforming Amendments.—

(1) TREATMENT OF BENEFITS.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(C) is amended, in the matter before clause (i), by inserting "or (E) after subparagraph (A)".

(2) PAYMENT OF MEDICARE PREMIUMS AND PART A DEDUCTIBLE.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended—

(A) by inserting "deductible amounts under part A and" after "(including expenditures for",

(B) by inserting "(and, in the case of qualified medicare beneficiaries described in section 1905(p)(1), part A)" after "premiums under part B", and

(C) by striking "or (B)" and inserting "(B) are qualified medicare beneficiaries described in section 1905(p)(1), or (C)".

(3) TIMING OF BENEFITS.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter before subdivision (i), by inserting "or, in the case of a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes a such a beneficiary" after "makes application for assistance".

(4) COPAYMENTS.—

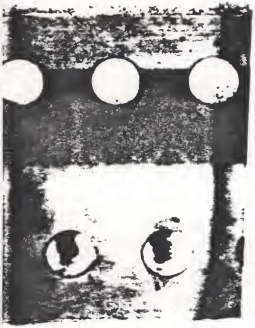
(A) Section 1902(a)(15) of such Act (42 U.S.C. 1396a(a)(15)) is amended by inserting "are not qualified medicare beneficiaries (as defined in section 1905(p)(1)) but" after "older who",

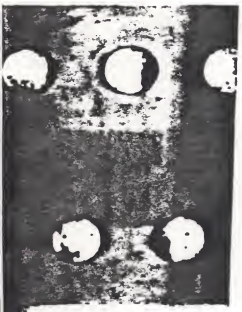
(B) Subsections (a) and (b) of section 1916 of such Act (42 U.S.C. 1396o) are each amended by striking "section 1902(a)(10)(A)" and inserting "subparagraph (A) or (E) of section 1902(a)(10)".

(h) EFFECTIVE DATE.—The amendments made by this section apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9404. MEDICAID ELIGIBILITY FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUALS

(a) AS CATEGORICALLY NEEDY.—Section 1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting "or who are qualified severely impaired individuals (as defined in section 1905(q))" after "title XVI".





(b) DESCRIPTION OF QUALIFIED SEVERELY IMPAIRED INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by section 9403(b) of this subtitle, is amended by adding at the end the following new subsection:

"(q) The term 'qualified severely impaired individual' means an individual under age 65—

"(1) who for the month preceding the first month to which this subsection applies to such individual—

"(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

"(B) was eligible for medical assistance under the State plan approved under this title; and

"(2) with respect to whom the Secretary determines that—

"(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was faund to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

"(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

"(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

"(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any Federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).".

(c) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure

IED SEVERELY IMPAIRED INDIVID-
t (42 U.S.C. 1396d), as amended by
s amended by adding at the end the

rely impaired individual' means an

preceding the first month to which
ich individual—
payment of supplemental security
section 1611(b) on the basis of blind-
a supplementary payment under sec-
or under section 212 of Public Law
(iii) a payment of monthly benefits
, or (iv) a supplementary payment
), and
r medical assistance under the State
his title; and
n the Secretary determines that—
continues to be blind or continues to
ysical or mental impairment on the
s found to be under a disability and,
s, continues to meet all non-disability-
for eligibility for benefits under title

such individual would not, except for
l to or in excess of the amount which
e ineligible for payments under section
erwise eligible for such payments),
igibility for benefits under this title
if his ability to continue or obtain em-

's earnings are not sufficient to allow
imself a reasonable equivalent of the
XVI (including any Federally adminis-
ntary payments), this title, and public-
care services (including personal care
d be available to him in the absence of

who is eligible for medical assistance
1 June, 1987, the individual shall be a
ndividual for so long as such individ-
paragraph (2).".
The amendments made by this section
der paragraph (2)) to payments under
ity Act for calendar quarters beginning
thout regard to whether regulations to
are promulgated by such date.
plan for medical assistance under title
Act which the Secretary of Health and
requires State legislation (other than
nds) in order for the plan to meet the
posed by the amendments made by this
l not be regarded as failing to comply
h title solely on the basis of its failure

to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

SEC. 9405. CLARIFICATION OF ELIGIBILITY OF HOMELESS INDIVIDUALS.

Section 1902(b)(2) of the Social Security Act (42 U.S.C. 1396a(b)(2)) is amended by inserting before the semicolon the following: ", regardless of whether or not the residence is maintained permanently or at a fixed address".

SEC. 9406. PAYMENT FOR ALIENS UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end thereof the following new subsection:

"(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

"(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

"(A) such care and services are necessary for the treatment of an emergency medical condition of the alien, and

"(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).

"(3) For purposes of this subsection, the term emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

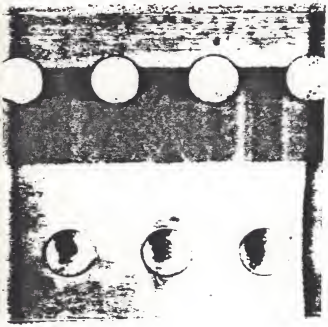
"(C) serious dysfunction of any bodily organ or part.".

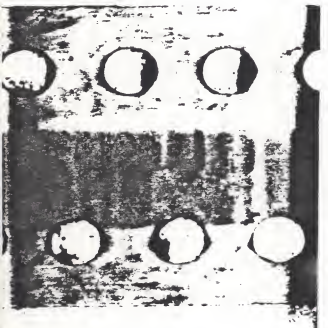
(b) CONFORMING AMENDMENT.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by adding at the end thereof the following new sentence: "Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently resuding in the United States under color of law only in accordance with section 1903(v).".

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished to aliens on or after January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legisla-





tion (other than legislation appropriating funds) in or
the plan to meet the additional requirement imposed
amendment made subsection (b), the State plan shall no
garded as failing to comply with the requirements of su
solely on the basis of its failure to meet such additional r
ment before the first day of the first calendar quarter beg
after the close of the first regular session of the State legi
that begins after the date of the enactment of this Act.

SEC. 9407. OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PRE
WOMEN.

(a) STATE OPTION.—Section 1902(a) of such Act (42
1396a(a)) is amended—

(1) by striking "and" at the end of paragraph (45),

(2) by striking the period at the end of paragraph (46) a
serting in lieu thereof "; and", and

(3) by adding at the end the following:

"(47) at the option of the State, provide for making am
ry prenatal care available to pregnant women during
sumptive eligibility period in accordance with section 192

(b) PRESUMPTIVE ELIGIBILITY.—Title XIX of the Social S
Act is amended by redesignating section 1920 as section 19
inserting after section 1919 the following new section:

"PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

"SEC. 1920. (a) A State plan approved under section 1902 m
vide for making ambulatory prenatal care available to a pr
woman during a presumptive eligibility period.

"(b) For purposes of this section—

"(1) the term 'presumptive eligibility period' means, with
to a pregnant woman, the period that—

"(A) begins with the date on which a qualified p
determines, on the basis of preliminary informatio
the family income of the woman does not exceed the
cable income level of eligibility under the State pla

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is mac
respect to the eligibility of the woman for medi
sistance under the State plan,

"(ii) the day that is 45 days after the date on
the provider makes the determination referrec
subparagraph (A), or

"(iii) in the case of a woman who does not file
plication for medical assistance within 14 ca
days after the date on which the provider ma
determination referred to in subparagraph (A
fourteenth calendar day after such determina
made; and

"(2) the term 'qualified provider' means any provider

"(A) is eligible for payments under a State plan ap
under this title,

"(B) provides services of the type described in su
graph (A) or (B) of section 1905(a)(2) or in section 190

n appropriating funds) in order for itional requirement imposed by the n (b), the State plan shall not be re- v with the requirements of such title ilure to meet such additional require- the first calendar quarter beginning egular session of the State legislature f the enactment of this Act.

E ELIGIBILITY PERIOD FOR PREGNANT

1902(a) of such Act (42 U.S.C.

he end of paragraph (45), at the end of paragraph (46) and in- d", and the following:

State, provide for making ambulato- e to pregnant women during a pre- in accordance with section 1920.".

Y.—Title XIX of the Social Security ing section 1920 as section 1921 and following new section:

ILITY FOR PREGNANT WOMEN

approved under section 1902 may pro- prenatal care available to a pregnant eligibility period.

ion—

eligibility period' means, with respect od that—

ie date on which a qualified provider asis of preliminary information, that the woman does not exceed the appli- eligibility under the State plan, and l includes) the earlier of—

which a determination is made with gibility of the woman for medical as- e State plan,

iat is 45 days after the date on which kes the determination referred to in), or

se of a woman who does not file an ap- edical assistance within 14 calendar late on which the provider makes the eferred to in subparagraph (A), the ıdar day after such determination is

d provider' means any provider that— payments under a State plan approved

ices of the type described in subpara- ection 1905(a)(2) or in section 1905(a)(9),

"(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

"(D)(i) receives funds under—

"(I) section 329 or section 330 of the Public Health Service Act, or

"(II) title V of this Act;

"(ii) participates in the program established under—

"(I) section 17 of the Child Nutrition Act of 1966, or

"(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973; or

"(iii) participates in a State perinatal program.

"(c)(1) The State agency shall provide qualified providers with—

"(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

"(B) information on how to assist such women in completing and filing such forms.

"(2) A qualified provider that determines under subection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

"(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan within 14 calendar days after the date on which the determination is made.

"(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan within 14 calendar days after the date on which the determination is made.

"(d) Notwithstanding any other provision of this title, ambulatory prenatal care that—

"(1) is furnished to pregnant woman—

"(A) during a presumptive eligibility period,

"(B) by a qualified provider; and

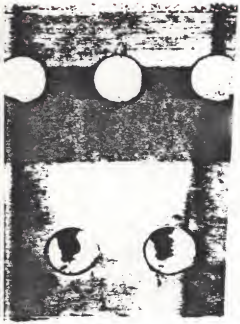
"(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.".

(c) CONFORMING CHANGE.—Section 1903(u)(1)(D) of such Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following:

"(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)).".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.





SEC. 9408. RESPIRATORY CARE SERVICES FOR VENTILATOR-DEPENDENT INDIVIDUALS.

(a) REQUIRED SERVICES.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396b(e)), as amended by sections 9401(d) and 9403(f) of this subtitle, is further amended by adding at the end the following new paragraph:

"(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

"(i) is medically dependent on a ventilator for life support at least six hours per day;

"(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, which ever is less) as an inpatient;

"(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, skilled nursing facility, or intermediate care facility, and would be eligible to have payment made for such inpatient care under the State plan;

"(iv) has adequate social support services to be cared for at home; and

"(v) wishes to be cared for at home.

"(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, skilled nursing facilities, or intermediate care facilities.

"(C) For purposes of this paragraph, respiratory care service means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.".

(b) WAIVER OF COMPARABILITY.—Section 1902(a)(10) of such Act (42 U.S.C. 1396(a)(10)), as amended by sections 9401(c), 9403(a), and 9403(c) of this subtitle, is further amended, in the matter following subparagraph (E)—

(1) by striking "and" before "(VIII)"; and

(2) by inserting before the semicolon at the end thereof the following: ", and (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection".

(c) CONFORMING CHANGES.—

(1) Section 1905(a) of the Social Security Act (42 U.S.C. 1395d(a)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is further amended—

(A) by striking "and" at the end of paragraph (19),

(B) by redesignating paragraph (20) as paragraph (21), and

RVICES FOR VENTILATOR-DEPENDENT

ion 1902(e) of the Social Security
ded by sections 9401(d) and 9403(f)
ed by adding at the end the follow-

he State, the plan may include as
ry care services for any individual

ndent on a ventilator for life sup-
er day;
endent for at least 30 consecutive
number of days authorized under
er is less) as an inpatient;
lability of respiratory care services,
ry care as an inpatient in a hospi-
ility, or intermediate care facility,
have payment made for such inpa-
te plan;
cial support services to be cared for

l for at home.
subparagraph (A)(ii) may be satis-
one or more hospitals, skilled nurs-
e care facilities.
paragraph, respiratory care service
a part-time basis in the home of the
therapist or other health care pro-
tory therapy (as determined by the
is not otherwise included within
nished to such individual as medi-
n.".
ry.—Section 1902(a)(10) of such Act
ded by sections 9401(c), 9403(a), and
er amended, in the matter following

re "(VIII)"; and
semicolon at the end thereof the fol-
aking available of respiratory care
subsection (e)(9) shall not, by reason
uire the making available of such
ailable of such services of the same
pe, to any individuals not included
provided such services are made
unt, duration, and scope) to all indi-
ubsection".

he Social Security Act (42 U.S.C.
section 1895(c)(3) of the Tax Reform
nded—
" at the end of paragraph (19),
paragraph (20) as paragraph (21),

(C) by inserting after paragraph (19) the following new paragraph:

"(20) respiratory care services (as defined in section 1902(e)(9)(C)); and".

(2) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is amended by striking "(20)" and inserting in lieu thereof "(21)".

(3) Section 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is amended by striking "through (19)" and inserting in lieu thereof "through (20)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date of the enactment of this Act.

PART 2—PROVISION OF SERVICES UNDER WAIVER AUTHORITY

SEC. 9411. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO CERTAIN LOW-INCOME INDIVIDUALS.

(a) WAIVER AUTHORITY.—

(1) Section 1915(c)(1) of the Social Security Act (42 U.S.C. 1396n(c)(1)) is amended—

(A) by inserting "a hospital or" after "level of care provided in", and

(B) by striking out all beginning with "or but for" through "State plan" the third place it appears.

(2) Section 1915(c)(2)(B) of such Act is amended—

(A) in clause (i) by striking "skilled nursing facility or" and inserting in lieu thereof "inpatient hospital, skilled nursing facility, or", and

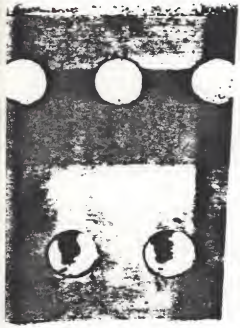
(B) in the matter following clause (iii) by inserting "inpatient hospital" after "need for".

(3) Section 1915(c)(7) of such Act is amended to read as follows:

"(7) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in hospitals or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients of those respective facilities.".

(b) PROVIDING CASE MANAGEMENT SERVICES TO PATIENTS WITH CERTAIN CONDITIONS.—Section 1915(g)(1) of such Act is amended by adding at the end the following: "A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness.".

(c) WAIVER OF COMPARABILITY REQUIREMENT.—The first sentence of section 1915(c)(3) of such Act is amended by striking all that fol-





lows "statewideness)" and inserting "and section 1902(a)(10)(B) (relating to comparability),".

(d) PROVIDING CERTAIN OTHER SERVICES TO PATIENTS WITH CHRONIC MENTAL ILLNESS.—Section 1915(c)(4)(B) of such Act is amended by inserting before the period at the end the following: "and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to applications for waivers (or renewals thereof) approved on or after the date of the enactment of this Act.

SEC. 9412. WAIVER AUTHORITY FOR CHRONICALLY MENTALLY ILL AND FRAIL ELDERLY.

(a) CHRONICALLY MENTALLY ILL DEMONSTRATION PROGRAM.—

(1) The Secretary of Health and Human Services may, in accordance with this subsection, waive certain provisions of title XIX of the Social Security Act in order to allow States to implement demonstration programs to improve the continuity, quality, and cost-effectiveness of mental health services available to chronically mentally ill medicaid beneficiaries.

(2) A waiver shall be granted under this subsection with respect to a demonstration program only if—

(A) the demonstration program has been awarded a grant from the Robert Wood Johnson Foundation and the Department of Housing and Urban Development under their "Program for the Chronically Mentally Ill",

(B) the State provides assurances satisfactory to the Secretary that under such waiver—

(i) the average per capita expenditure estimated by the State in any fiscal year for medical assistance for mental health services provided with respect to individuals covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such services for such individuals if the waiver had not been granted, and

(ii) there will be no reduction or limitation in benefits to a medicaid beneficiary under the program.

(3) The authority under this subsection extends only to the following, as they relate to the provision of mental health services:

(A) A waiver of the requirements of sections 1902(a)(1), 1920(a)(10)(B), 1902(a)(23), and 1902(a)(30) and clauses (i) and (ii) of section 1903(m)(2) of the Social Security Act.

(B) Including as "medical assistance" under the State plan case management services with respect to mentally ill patients, habilitation services (as defined in section 1915(c)(5) of such Act), day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the State may request and the Secretary may ap-

prove for individuals covered under the demonstration project.

(4)(A) A waiver under this subsection shall be for an initial term of three years which may be extended for an additional two-year term. The request of a State for extension of such a waiver shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

(B) The authority to approve a waiver under this subsection extends only during the five-year period beginning on October 1, 1986.

(5) Subsections (c)(6) and (e)(1) of section 1915 of the Social Security Act shall apply to a waiver under this subsection in the same manner as they apply to a waiver under that section.

(6) The Secretary shall report, not later than January 1, 1993, to Congress on the cost, accessibility, utilization, and quality of service provided under waivers granted under this subsection.

(b) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

(1) The Secretary of Health and Human Services shall grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or nonprofit private community-based organizations to enable such organizations to provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization.

(2)(A) Except as provided in subparagraph (B), the terms and conditions of a waiver granted pursuant to this subsection shall be substantially the same as the terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985).

(B) In order to receive a waiver under this subsection, an organization must be awarded a grant from the Robert Wood Johnson Foundation.

(C) Subject to subparagraph (B), any waiver granted pursuant to this subsection shall be for an initial period of 3 years. The Secretary may extend such waiver beyond such initial period for so long as the Secretary finds that the organization complies with the terms and conditions described in subparagraphs (A) and (B).

SEC. 9413. CONTINUATION OF "CASE-MANAGED MEDICAL CARE FOR NURSING HOME PATIENTS" DEMONSTRATION PROJECT.

(a) APPROVAL OF APPLICATION.—The Secretary of Health and Human Services shall approve any application for a waiver of any requirement of title XVIII or XIX of the Social Security Act necessary to provide for continuation, from July 1, 1987, through June 30, 1989, of the "Case-Managed Medical Care for Nursing Home Patients" demonstration project (#95-P-98346/1-01) carried out pursuant to section 222 of the Social Security Amendments of 1972, section 402 of the Social Security Amendments of 1967, and section 1115 of the Social Security Act by the Department of Public Welfare, Commonwealth of Massachusetts.

(b) TERMS AND CONDITIONS.—The Secretary's approval of an application (or renewal of an application) under subsection (a) shall be

on the same terms and conditions as applied to the demonstration project on July 1, 1986.

SEC. 9414. NEW JERSEY RESPITE CARE PILOT PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with the State of New Jersey (in this section referred to as the "State") for the purpose of conducting a pilot project (in this section referred to as the "project") under the XIX of the Social Security Act for providing respite care services for elderly and disabled individuals in order to determine the extent to which—

(1) the provision of necessary respite care services to individuals at risk of institutionalization will delay or avert the need for institutional care, and

(2) respite care services enhance and sustain the role of the family in providing long-term care services for elderly and disabled individuals at risk of institutionalization.

(b) CONDITIONS.—The agreement with the Secretary under this section shall—

(1) provide that the project shall be administered by a State health services agency designated for such purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act);

(2) provide that if the project imposes any cost sharing requirements on participants who are eligible for benefits under title XIX of the Social Security Act, such requirements shall be imposed only in accordance with the provisions of section 1916 of such Act.

(3) provide for a system of review to assure that respite care services are provided only to individuals reasonably determined to be in need of such services, and

(4) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(c) DEFINITION.—For purposes of this section, the term "respite care services" shall include—

(1) short-term and intermittent—

(A) companion or sitter services (paid as well as volunteer),

(B) homemaker and personal-care services,

(C) adult day care, and

(D) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any individual); and

(2) peer support and training for family caregivers (using informal support groups and organized counseling).

(d) PAYMENTS.—The agreement under this section shall be entered into between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as an additional payment under section 1903 of the Social Security Act for each quarter, an amount equal to 50 percent of the reasonable costs incurred by such State during such quarter in providing respite care services under the project for elderly and disabled individuals who are eligible for medical assistance under the

ns as applied to the demonstration

RE PILOT PROJECT.
retary of Health and Human Ser-
as the "Secretary") shall enter into
New Jersey (in this section referred
se of conducting a pilot project (in
roject") under the XIX of the Social
te care services for elderly and dis-
termine the extent to which—
ary respite care services to individ-
ization will delay or avert the need

nhance and sustain the role of the
rm care services for elderly and dis-
institutionalization.
ent with the Secretary under this

ct shall be administered by a State
nated for such purpose by the Gover-
te agency administering or responsi-
of the State plan for medical assist-
Social Security Act);
roject imposes any cost sharing re-
who are eligible for benefits under
rity Act, such requirements shall be
with the provisions of section 1916

of review to assure that respite care
o individuals reasonably determined
es, and
rements as the Secretary may estab-
icient implementation of the project.
es of this section, the term "respite

ittent—
tter services (paid as well as volun-

personal-care services,
nd
a hospital, a skilled nursing facility,
e facility (not to exceed a total of 14
il); and
ining for family caregivers (using in-
organized counseling).
nt under this section shall be entered
the State agency designated by the
ent the Secretary shall pay to the
it under section 1903 of the Social Se-
n amount equal to 50 percent of the
ch State during such quarter in pro-
nder the project for elderly and dis-
gible for medical assistance under the

State plan approved under title XIX of such Act (or who would be eligible if coverage under such plan was as broad as allowed under Federal law). The Federal payment shall not exceed $1,000,000 for fiscal year 1987, and $2,000,000 for each of the fiscal years 1988, 1989, and 1990. No payments shall be made pursuant to this section for any fiscal year beginning after September 30, 1990.

(e) DURATION.—The project under this section shall be of maximum duration of four years, plus an additional time period of up to six months for final evaluation and reporting.

(f) REPORTS.—The State shall arrange for an independent evaluation of the project and shall transmit the evaluation to the Secretary not more than six months after the conclusion of project.

(g) PROVISIONS SUBJECT TO WAIVER.—At the request of the State, the Secretary shall waive the following provisions of title XIX of the Social Security Act as they relate to the pilot project: section 1902(a)(1), section 1902(a)(10)(B), section 1902(a)(13), and section 1902(a)(30). The Secretary may not waive any other provision of such title with respect to the pilot project.

SEC. 9415. INAPPLICABILITY OF PAPERWORK REDUCTION ACT.

Notwithstanding any other provision of law, chapter 35 of title 44, United States Code, shall not apply to information required to carry out any provision of this part or the amendments made by this part.

PART 3—PAYMENTS

SEC. 9421. HOLDING STATES HARMLESS IN FISCAL YEAR 1987 AGAINST A DECREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) IN GENERAL.—Section 9528 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end the following new subsection:

(c) HOLD HARMLESS PROVISION.—Notwithstanding subsection (b), for calendar quarters occurring during fiscal year 1987 and only for purposes of making payment to a State under section 1903 of the Social Security Act, the amendments made by subsection (a) shall not apply to a State if the effect of applying the amendments would be to reduce the amount of payment made to the State under that section.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective as though it had been included in the Consolidated Omnibus Budget Reconciliation Act of 1985 at the time of its enactment.

SEC. 9422. WAIVER OF CERTAIN REQUIREMENTS.

Notwithstanding the three-month limitation set forth in sections 1902(a)(34) and 1905(a) of the Social Security Act, payment may be made under title XIX of such Act with respect to care and services provided by the Medical University of South Carolina, after September 30, 1984, and before July 1, 1985, to individuals—

(1) who are not described in section 1902(a)(10)(A) of such Act,

(2) who, upon application, would have been eligible as individuals under the age of 18 or pregnant women, for medical assistance under the State plan approved under such title at the time such care and services were provided, and

(3) who, not later than six months after the date of the enactment of this Act, are determined by the State agency administering or supervising the administration of such plan to have been so eligible.

PART 4—OTHER QUALITY AND EFFICIENCY MEASURES

SEC. 9431. INDEPENDENT QUALITY REVIEW OF HMO SERVICES.

(a) IN GENERAL.—Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30)) is amended—

(1) by inserting "and" at the end of subparagraph (B), and

(2) by adding at the end the following new subparagraph:

"(C) provide a utilization and quality control peer review organization (under part B of title XI) or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1903(m), with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;".

(b) CONFORMING AMENDMENTS.—(1) Section 1902(d) of such Act (42 U.S.C. 1396a(d)) is amended by inserting "(including quality review functions described in subsection (a)(30)(C))" after "medical or utilization review functions".

(2) Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended by inserting "or quality review" after "medical and utilization review".

(c) EFFECTIVE DATE.—The amendments made by this section apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9432. STATE UTILIZATION REVIEW SYSTEMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") may not, during the period beginning with the date of the enactment of this Act and ending with the date that is 180 days after the day on whch the report required by subsection (b) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program requiring second surgical opinions or a program of inpatient hospital preadmission review.

(b) REPORT.—

(1) The Secretary shall report to Congress, by not later than October 1, 1988, for each State in a representative sample of States—

(A) the identity of those procedures which are high volume or high cost procedures among patients who are covered under the State medicaid plan,

(B) the payment rates under those plans for such procedures, and the aggregate annual payment amounts made under such plans for such procedures (including the Federal share of such payment amounts),

x months after the date of the enact-
·mined by the State agency adminis-
idministration of such plan to have

·Y AND EFFICIENCY MEASURES

REVIEW OF HMO SERVICES.

)2(aX30) of the Social Security Act (42
—

the end of subparagraph (B), and
the following new subparagraph:
and quality control peer review orga-
title XI) or a private accreditation
nual basis) an independent, external
rvices furnished under each contract
th the results of such review made
l, upon request, to the Secretary, the
Department of Health and Human
ler General;".

TS.—(1) Section 1902(d) of such Act
ded by inserting "(including quality
subsection (aX30XC))" after "medical
"

such Act (42 U.S.C. 1396b(aX3XC)) is
lity review" after "medical and utili-

amendments made by this section
XIX of the Social Security Act for cal-
after July 1, 1987, without regard to
is to carry out such amendments have

VIEW SYSTEMS.

etary of Health and Human Services
the "Secretary") may not, during the
te of the enactment of this Act and
180 days after the day on which the
(b) is submitted to the Congress, pub-
gulations requiring a State plan ap-
Social Security Act to include a pro-
al opinions or a program of inpatient

report to Congress, by not later than
State in a representative sample of

f those procedures which are high
rocedures among patients who are cov-
nedicaid plan,
tes under those plans for such proce-
gate annual payment amounts made
such procedures (including the Feder-
ent amounts),

(C) the rate at which each such procedure is performed on medicaid patients and (to the extent that data are available) comparisons to the rate at which such procedure is performed on patients of comparable age who are not medicaid patients,

(D) with respect to each such procedure—

(i) the number of board certified or board eligible physicians in the State who provide care and services to medicaid patients and who perform the procedure, and

(ii) in the case of a State with a mandatory second surgical opinion program in operation, the number of physicians described in clause (i) who provide second opinions (of the type described in section 1164 of the Social Security Act) for the procedure at prevailing payment rates under the State medicaid plan, and

(E) in the case of a State with a mandatory second surgical opinion program or a program of inpatient hospital preadmission review in operation, a description of—

(i) the extent to which such program impedes access to necessary care and services, and

(ii) the measures that the State has taken to address such impediments, particularly in rural areas.

(2) Such report shall also include a list of those surgical procedures which the Secretary believes meet the following criteria and for which a mandatory second opinion program under medicaid plans may be appropriate:

(A) The procedure is one which generally can be postponed without undue risk to the patient.

(B) The procedure is a high volume procedure among patients who are covered under State medicaid plans or is a high cost procedure.

(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why requiring second opinions for 100 percent of such procedures would be cost effective.

(3) The representative sample of States required to be included in the report shall include States with mandatory second surgical opinion programs in operation, States with programs of inpatient hospital preadmission review in operation, and States with neither such program in operation.

(4) In this subsection, the term "medicaid plan" means a State plan approved under title XIX of the Social Security Act.

(c) STUDY.—

(1) The Secretary shall conduct a study of the utilization of selected medical treatments and surgical procedures by medicaid beneficiaries in order to assess the appropriateness, necessity, and effectiveness of such treatments and procedures.

(2) The study shall analyze the extent to which there is significant variation in the rate of utilization by medicaid beneficiaries of selected treatments and procedures for different geographic areas within States and among States.

(3) The study shall also identify underutilized, medically necessary treatments and procedures for which—

(A) a failure to furnish could have an adverse effect on health status, and

(B) the rate of utilization by medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

(4) The study shall be coordinated, to the extent practicable, with the research program established pursuant to section 1875(c) of the Social Security Act, with particular regard to the relationship of the variations described in paragraph (2) to patient outcomes.

(5) The Secretary shall report the results of the study to the Congress not later than January 1, 1990.

SEC. 9433. CLARIFICATION OF FLEXIBILITY FOR STATE MEDICAID PAYMENT SYSTEMS FOR INPATIENT SERVICES.

(a) IN GENERAL.—Section 2173 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35, 95 Stat. 809) is amended by adding at the end the following new subsection:

"(d) Section 1902 of such Act is further amended by insertng before subsection (i) the following new subsection:

"'(h) Nothing in this title (inlcuding subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a plan under this title with respect to hospitals that serve a disproportionate number of low-income patients with special needs.'.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as though it was included in the enactment of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35).

SEC. 9434. FINANCIAL DISCLOSURE REQUIREMENTS FOR HMOS; CIVIL MONEY PENALTIES.

(a) DISCLOSURE OF INTERLOCKING RELATIONSHIPS.—

(1) Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(A) in paragraph (2)(A)—

(i) by striking "and" at the end of clause (vi),

(ii) by striking the period at the end of clause (vii) and inserting ", and", and

(iii) by adding after clause (vii) the following new clause:

"(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection."; and

(B) by adding at the end the following new paragraph:

"(4)(A) Each health maintenance organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

dentify underutilized, medically nec-
dures for which—
ish could have an adverse effect on

ation by medicaid beneficiaries is sig-
he rate for comparable, age-adjusted

oordinated, to the extent practicable,
m established pursuant to section
ity Act, with particular regard to the
ons described in paragraph (2) to pa-

report the results of the study to the
nuary 1, 1990.

LEXIBILITY FOR STATE MEDICAID PAY-
INPATIENT SERVICES.

73 of the Omnibus Budget Reconcilia-
97–35, 95 Stat. 809) is amended by
g new subsection:
Act is further amended by insertng
ing new subsection:
ncluding subsections (a)(13) and (a)(30)
trued as authorizing the Secretary to
adjustments that may be made under
espect to hospitals that serve a dispro-
me patients with special needs.'.".
amendment made by subsection (a)
included in the enactment of the Om-
Act of 1981 (Public Law 97–35).

URE REQUIREMENTS FOR HMOS; CIVIL

CKING RELATIONSHIPS.—
f the Social Security Act (42 U.S.C.

2)(A)—
"and" at the end of clause (vi),
g the period at the end of clause (vii)
and", and
g after clause (vii) the following new

rovides for disclosure of information in
1124 and paragraph (4) of this subsec-

he end the following new paragraph:
ntenance organization which is not a
ice organization (as defined in section
h Service Act) must report to the State
cretary, the Inspector General of the De-
man Services, and the Comptroller Gen-
actions between the organization and a
' in section 1318(b) of such Act), includ-
ns:

"(i) Any sale or exchange, or leasing of any property between the organization and such a party.

"(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

"(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity by in the form of a consolidated financial statement for the organization and such entity.

"(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.".

(2) Section 1903(m)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by inserting before the semicolon the following: "and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $100,000".

(3)(A) The amendments made by paragraph (1) shall take effect 6 months after the date of the enactment of this Act.

(B) The amendment made by paragraph (2) shall take effect on the date of the enactment of this Act and shall apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on the date of the enactment of this Act.

(c) CIVIL MONEY PENALTIES.—Section 1903(m) of the Social Security Act, as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(5)(A) Any entity with a contract under this subsection that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.".

SEC. 9435. COBRA TECHNICAL CORRECTIONS AND CLARIFICATIONS RELATING TO THE MEDICAID PROGRAM.

(a) MAINTENANCE INCOME STANDARDS.—Section 9502(j)(4) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking out "on or after" and inserting in lieu thereof "before, on, or after".

(b) HOSPICE CARE FOR DUAL ELIGIBLES.—

(1) Section 1902(a)(13)(D) of the Social Security Act, as amended by sections 9505(c)(01) and 9509(a)(4) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by inserting before the first semicolon the following: "and for payment of amounts under section 1905(o)(3)".

(2) Section 1905(o) of the Social Security Act, as amended by section 9505(a)(2) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

"(3) In the case of a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to an individual—

"(A) who is residing in a skilled nursing or intermediate care facility and is receiving medical assistance for services in such facility under the plan,

"(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

"(C) with respect to whom the hospice program under such title and the skilled nursing or intermediate care facility have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13), and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4). For purposes of this paragraph and section 1902(a)(13)(D), the term 'room and board' includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.".

(c) MEDICAID QUALIFYING TRUSTS.—Section 9506 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end the following new subsection:

"(c) EXCEPTION.—The amendment made by subsection (a) shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.".

(d) EFFECTIVE DATES.—

(1) Sections 9505(e) and 9508(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 are each amended by inserting before the period at the end the following: ", without regard to whether or not regulations to carry out the amendments have been promulgated by that date".

(2) Sections 9510(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 are each amended by inserting before the period at the end the following: ", without regard to whether or not regulations to carry out the amendment have been promulgated by that date".

e Social Security Act, as amended by
nsolidated Omnibus Budget Reconcil-
nded by adding at the end the follow-

te which elects not to provide medical
e, but provides medical assistance for
iediate care facility services with re-

g in a skilled nursing or intermediate
ceiving medical assistance for services
the plan,
ed to benefits under part A of title
d, under section 1812(d), to receive hos-
part, and
to whom the hospice program under
tilled nursing or intermediate care fa-
nto a written agreement under which
ull responsibility for the professional
ndividual's hospice care and the facili-
oom and board to the individual,
otherwise made under the plan with re-
vices, the State shall provide for pay-
rogram of an amount equal to the
r the plan for room and board in the
ith the rates established under section
ndividual is an individual described in
all provide for payment of any coinsur-
nder section 1813(a)(4). For purposes of
tion 1902(a)(13)(D), the term 'room and
nce of personal care services, including
of daily living, in socializing activities,
ation, maintaining the cleanliness of a
ervising and assisting in the use of du-
t and prescribed therapies.".

TRUSTS.—Section 9506 of the Consoli-
onciliation Act of 1985 is amended by
ing new subsection:

iendment made by subsection (a) shall
initial trust decree established prior to
benefit of a mentally retarded individ-
mediate care facility for the mentally re-

nd 9508(b) of the Consolidated Omnibus
Act of 1985 are each amended by insert-
the end the following: ", without regard
ations to carry out the amendments have
iat date".
f the Consolidated Omnibus Budget Rec-
5 are each amended by inserting before
he following: ", without regard to wheth-
carry out the amendment have been pro-
".

(e) HEALTH INSURING ORGANIZATIONS.—Section 9517(c)(2) of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 1895(c)(4) of the Tax Reform Act of 1986, is amended by adding at the end the following new subparagraph:

"(D) Nothing in section 1903(m)(1)(A) of the Social Security Act shall be construed as requiring a health-insuring organization to be organized under the health maintenance organization laws of a State.".

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

SEC. 9436. PAYMENT FOR CERTAIN LONG-TERM CARE PATIENTS IN HOSPITALS

(a) IN GENERAL.—In the case of a State which received a waiver under the authority of section 402(b) of the Social Security Amendments of 1967 with respect to payment methodology for inpatient hospital services under title XVIII and XIX of the Social Security Act during the 3-year period beginning January 1, 1983, notwithstanding section 1902(a)(13) of such Act, the State may pay under title XIX of such Act for hospital patients receiving services at an inappropriate level of care at the rate for hospital patients receiving an appropriate level of care if the Secretary of Health and Human Services determines that a sufficient number of hospital beds have been decertified in the State to reduce the payments to hospitals under such title in the State by amount equal to or greater that the amount by which payments to hospitals under such title in such State will increase as a result of the payment of such higher rates for patients receiving inappropriate levels of care.

(b) EFFECTIVE PERIOD.—Subsection (a) shall apply to payments for services furnished during the 3-year period beginning January 1, 1986, after the date the Secretary makes the determination described in that subsection.

PART 5—MATERNAL AND CHILD HEALTH

SEC. 9441. AUTHORIZATION AND ALLOTMENT OF ADDITIONAL FUNDS.

(a) ADDITIONAL FUNDS.—Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by striking "$478,000,000 for fiscal year 1984" and inserting "$553,000,000 for fiscal year 1987, $557,000,000 for fiscal year 1988, and $561,000,000 for fiscal year 1989".

(b) ALLOTMENT OF ADDITIONAL APPROPRIATIONS.—Section 502 of such Act (42 U.S.C. 701) is amended—

(1) in subsection (a)(1) by striking "amount appropriated under section 501(a)" and inserting in lieu thereof "amounts appropriated under section 501(a) for a fiscal year that are not in excess of $478,000,000";

(2) in subsection (b)—

(A) by inserting "that are not in excess of $478,000,000" after "fiscal year" the first place it appears, and

(B) by striking paragraph (3); and

(3) by adding at the end the following new subsections:

"(c)(1) Of the amounts appropriated for a fiscal year in excess of $478,000,000, an amount equal to 7 percent for fiscal year 1987, 8

percent for fiscal year 1988, and 9 percent for fiscal year 1989 shall be retained by the Secretary for the purpose of carrying out (through grants, contracts, or otherwise) projects for the screening of newborns for sickle-cell anemia and other genetic disorders. The provisions of paragraph (3) of subsection (a) shall apply to projects authorized by this paragraph to the same extent as such provisions apply to projects authorized under such subsection.

"(2)(A) Of the amounts appropriated for a fiscal year in excess of $478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 33⅓ percent shall be retained and allotted in the same manner as the amounts retained and allotted under subsections (a) and (b).

"(B) The amounts retained by the Secretary under this paragraph shall be used for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional or national significance, training, and research to promote access to primary health services for children and community-based service networks and case management services for children with special health care needs.

"(C) The amounts allotted to the States under this paragraph shall be used to develop primary health services demonstration programs and projects for children and to promote the development of community-based service networks and case management services for children with special health care needs.

"(D) For purposes of this paragraph—

"(i) the term 'primary health services' includes—

"(I) any assessment, diagnosis, or treatment service provided on an outpatient basis that is designed to promote the health, to prevent the development of disease or disability, or to treat an illness or other health condition, of a child, and

"(II) any service designed to promote the access of children to high quality, continuous, and comprehensive primary health services, including case management;

"(ii) the term 'community-base service network for children with special health care needs' means a network of coordinated, high-quality services that is located in or near the home communities of children with special health care needs in order to improve the health status, functioning, and well being of such children;

"(iii) the term 'case management services' means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children and their families; and

"(iv) the term 'comprehensive services' includes early identification and intervention services, diagnostic and evaluation services, treatment services, rehabilitation services, family support services, and special education services.

"(3) Of the amounts appropriated for a fiscal year in excess of $478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 66⅔ percent shall be retained and alloted in the

d 9 percent for fiscal year 1989 shall
the purpose of carrying out (through
) projects for the screening of new-
d other genetic disorders. The provi-
ection (a) shall apply to projects au-
the same extent as such provisions
der such subsection.
opriated for a fiscal year in excess of
the Secretary has retained the appli-
fiscal year under paragraph (1), an
shall be retained and allotted in the
retained and allotted under subsec-

by the Secretary under this paragraph
of carrying out (through grants, con-
ojects of regional or national signifi-
to promote access to primary health
mmunity-based service networks and
r children with special health care

to the States under this paragraph
ary health services demonstration pro-
en and to promote the development of
orks and case management services for
are needs.
ragraph—
ealth services' includes—
t, diagnosis, or treatment service pro-
nt basis that is designed to promote
the development of disease or disabil-
lness or other health condition, of a

esigned to promote the access of chil-
, continuous, and comprehensive pri-
including case management;
nity-base service network for children
needs' means a network of coordinated,
t is located in or near the home com-
h special health care needs in order to
s, functioning, and well being of such

anagement services' means services to
l efficient organization and utilization
ess to necessary comprehensive services
milies; and
ensive services' includes early identifi-
ervices, diagnostic and evaluation serv-
rehabilitation services, family support
ation services.
opriated for a fiscal year in excess of
er the Secretary has retained the appli-
ch fiscal year under paragraph (1), an
t shall be retained and allotted in the

same manner and for the same purposes as the amounts retained and allotted under subsections (a) and (b).

"(dX1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505 for the fiscal year or because some States have indicated in their descriptions of activities under section 505 that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

"(2) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(bX2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.".

SEC. 9442. MATERNAL AND CHILD HEALTH AND ADOPTION CLEARINGHOUSE.

The Secretary of Health and Human Services shall establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse shall—

(1) collect, compile, and maintain information obtained from available research, studies, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs;

(2) compile, maintain, and periodically revise directories of information concerning—

(A) crisis pregnancy centers,

(B) shelters and residences for pregnant women,

(C) training programs on adoption,

(D) educational programs on adoption,

(E) licensed adoption agencies,

(F) State laws relating to adoption,

(G) intercountry adoption,

(H) any other information relating to adoption for pregnant women, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field;

(3) disseminate the information compiled and maintained pursuant to paragraph (1) and the directories compiled and maintained pursuant to paragraph (2); and

(4) upon the establishment of an adoption and foster care data collection system pursuant to section 479 of the Social Security Act, disseminate the data and information made available through that system.

SEC. 9443. COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE.

Part E of title IV of the Social Security Act, as amended by section 1883(bX10) of the Tax Reform Act of 1986, is further amended by adding at the end thereof the following new section:

"COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE

"SEC. 579. (a)(1) Not later than 90 days after the date of the enactment of this subsection, the Secretary shall establish an Advisory Committee on Adoption and Foster Care Information (in this section referred to as the 'Advisory Committee') to study the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

"(2) The study required by paragraph (1) shall—

"(A) identify the types of data necessary to—

(i) assess (on a continuing basis) the incidence, characteristics, and status of adoption and foster care in the United States, and

"(ii) develop appropriate national policies with respect to adoption and foster care;

"(B) evaluate the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies;

"(C) assess the validity of various methods of collecting data with respect to adoption and foster care; and

"(D) evaluate the financial and administrative impact of implementing each such method.

"(3) Not later than October 1, 1987, the Advisory Committee shall submit to the Secretary and the Congress a report setting forth the results of the study required by paragraph (1) and evaluating and making recommendations with respect to the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

"(4)(A) Subject to subparagraph (B), the membership and organization of the Advisory Committee shall be determined by the Secretary.

"(B) The membership of the Advisory Committee shall include representatives of—

"(i) private, nonprofit organizations with an interest in child welfare (including organizations that provide foster care and adoption services),

"(ii) organizations representing State and local governmental agencies with responsibility for foster care and adoption services,

"(iii) organizations representing State and local governmental agencies with responsibility for the collection of health and social statistics,

"(iv) organizations representing State and local judicial bodies with jurisdiction over family law,

"(v) Federal agencies responsible for the collection of health and social statistics, and

"(vi) organizations and agencies involved with privately arranged or international adoptions.

"(5) After the date of the submission of the report required by paragraph (3), the Advisory Committee shall cease to exist.

han 90 days after the date of the enact-
Secretary shall establish an Advisory
Foster Care Information (in this section
Committee') to study the various meth-
ering, and financing a system for the
ct to adoption and foster care in the

paragraph (1) shall—
of data necessary to—
tinuing basis) the incidence, character-
adoption and foster care in the United

priate national policies with respect to
are;
bility and appropriateness of collecting
vately arranged adoptions and adop-
private agencies without assistance
agencies;
of various methods of collecting data
nd foster care; and
cial and administrative impact of im-
thod.
1, 1987, the Advisory Committee shall
he Congress a report setting forth the
by paragraph (1) and evaluating and
h respect to the various methods of es-
d financing a system for the collection
option and foster care in the United

raph (B), the membership and organi-
ittee shall be determined by the Secre-

he Advisory Committee shall include

rganizations with an interest in child
izations that provide foster care and

esenting State and local governmental
ity for foster care and adoption serv-

esenting State and local governmental
lity for the collection of health and

presenting State and local judicial
ver family law,
esponsible for the collection of health

l agencies involved with privately ar-
doptions.
submission of the report required by
mmittee shall cease to exist.

"(b)(1)(A) Not later than July 1, 1988, the Secretary shall submit to the Congress a report that—

"(i) proposes a method of establishing, administering, and financing a system for the collection of data relating to adoption and foster care in the United States,

"(ii) evaluates the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies, and

"(iii) evaluates the impact of the system proposed under clause (i) on the agencies with responsibility for implementing it.

"(B) The report required by subparagraph (A) shall—

"(i) specify any changes in law that will be necessary to implement the system proposed under subparagraph (A)(i), and

"(ii) describe the type of system that will be implemented under paragraph (2) in the absence of such changes.

"(2) Not later than December 31, 1988, the Secretary shall promulgate final regulations providing for the implementation of—

"(A) the system proposed under paragraph (1)(A)(i), or

"(B) if the changes in law specified pursuant to paragraph (1)(B)(i) have not been enacted, the system described in paragraph (1)(B)(ii).

Such regulations shall provide for the full implementation of the system not later than October 1, 1991.

"(c) Any data collection system developed and implemented under this section shall—

"(1) avoid unnecessary diversion of resources from agencies responsible for adoption and foster care;

"(2) assure that any data that is collected is reliable and consistent over time and among jurisdictions through the use of uniform definitions and methodologies;

"(3) provide comprehensive national information with respect to—

"(A) the demographic characteristics of adoptive and foster children and their biological and adoptive or foster parents,

"(B) the status of the foster care population (including the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care),

"(C) the number and characteristics of—

"(i) children placed in or removed from foster care, and

"(ii) children adopted or with respect to whom adoptions have been terminated, and

"(D) the extent and nature of assistance provided by Federal, State, and local adoption and foster care programs and the characteristics of the children with respect to whom such assistance is provided; and

"(4) utilize appropriate requirements and incentives to ensure that the system functions reliably throughout the United States.".

SUBTITLE F—PROVISION RELATING TO ACCESS TO HEALTH CARE

Sec. 9501. Continuation coverage for retirees in cases of bankruptcies.

SEC. 9501. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES.

(a) LOSS OF COVERAGE OF RETIREE THROUGH BANKRUPTCY AS QUALIFYING EVENT.—

(1) IRC AMENDMENT.—Paragraph (3) of section 162(k) of the Internal Revenue Code of 1986 (relating to qualifying event with respect to continuation coverage requirements under group health plans) is amended by adding at the end the following:

"(F) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in subparagraph (F), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in paragraph (7)(B)(iv) within one year before or after the date of commencement of the proceeding."

(2) ERISA AMENDMENT.—Section 603 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163) is amended by adding at the end the following:

"(6) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 607(3)(C) within one year before or after the date of commencement of the proceeding."

(b) PERIOD OF CONTINUATION COVERAGE.—

(1) LIFE OF COVERED EMPLOYEE OR WIDOW AND ADDITIONAL 36 MONTHS FOR SURVIVING SPOUSE AND DEPENDENTS.—

(A) IRC AMENDMENTS.—Clause (i) of section 162(k)(2)(B) of the Internal Revenue Code of 1986 (relating to maximum period), as amended by section 1895(d)(2)(A) of the Tax Reform Act of 1986, is amended—

(i) in subclause (II), by inserting "other than a qualifying event described in paragraph (3)(F))" after "qualifying event" the first place it appears,

(ii) in subclause (III), by inserting "or (3)(F)" after "(3)(B)",

(iii) by redesignating subclause (III) as subclause (IV), and

(iv) by inserting after subclause (II) the following new subclause:

"(III) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in paragraph (3)(F) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in paragraph (7)(B)(iv)(III), or in the case of the surviving spouse or dependent children of the covered em-

ELATING TO ACCESS TO HEALTH CARE

retirees in cases of bankruptcies.

RAGE FOR RETIREES IN CASES OF BANK-

F RETIREE THROUGH BANKRUPTCY AS

-Paragraph (3) of section 162(k) of the
of 1986 (relating to qualifying event
tion coverage requirements under group
:d by adding at the end the following:
in a case under title 11, United States
)n or after July 1, 1986, with respect to
vhose employment the covered employee

described in subparagraph (F), a loss of
tantial elimination of coverage with re-
ficiary described in paragraph (7)(B)(iv)
r after the date of commencement of the

T.—Section 603 of the Employee Retire-
Act of 1974 (29 U.S.C. 1163) is amended
e following:
case under title II, United States Code,
July 1, 1986, with respect to the employ-
ent the covered employee retired at any

ribed in paragraph (6), a loss of coverage
nination of coverage with respect to a
bed in section 607(3)(C) within one year
)mmencement of the proceeding."

ON COVERAGE.—
EMPLOYEE OR WIDOW AND ADDITIONAL
NG SPOUSE AND DEPENDENTS.—
ENTS.—Clause (i) of section 162(k)(2)(B) of
ue Code of 1986 (relating to maximum
ed by section 1895(d)(2)(A) of the Tax
is amended—
se (II), by inserting "other than a qualify-
ibed in paragraph (3)(F))" after "qualify-
first place it appears,
ause (III), by inserting "or (3)(F)" after

ignating subclause (III) as subclause (IV),

ing after subclause (II) the following new

ULE FOR CERTAIN BANKRUPTCY PROCEED-
of a qualifying event described in para-
ng to bankruptcy proceedings), the date of
overed employee or qualified beneficiary
graph (7)(B)(iv)(III), or in the case of the
)r dependent children of the covered em-

ployee, 36 months after the date of the death of the covered employee."

(B) ERISA AMENDMENTS.—Subparagraph (A) of section 602(2) of the Employee Retirement Income Security Act of 1974 (relating to maximum period), as amended by section 1895(d)(B) of the Tax Reform Act of 1986, is amended—

(i) in clause (ii), by inserting "(other than a qualifying event described in section 603(6))" after "qualifying event" the first place it appears,

(ii) in clause (iii), by inserting "or 603(6)" after "603(2)",

(iii) by redesignating clause (iii) as clause (iv), and

(iv) by inserting after clause (ii) the following new subclause:

"(iii) SPECIAL RULE FOR CERTAIN BANKRUPTCY PROCEEDINGS.—In the case of a qualifying event described in 603(6) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 607(3)(C)(iii)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee."

(2) COVERAGE NOT LOST UPON ENTITLEMENT TO MEDICARE BENEFITS.—

(A) IRC AMENDMENT.—Subclause (II) of section 162(k)(2)(B)(iv) of the Internal Revenue Code of 1986 (relating to reemployment or medicare eligibility) is amended by inserting "in the case of a qualified beneficiary other than a qualified beneficiary described in paragraph (7)(B)(iv)," before "entitled".

(B) ERISA AMENDMENT.—Clause (ii) of section 602(2)(D) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(D)) is amended by inserting "in the case of a qualified beneficiary other than a qualified beneficiary described in section 607(3)(C)," before "entitled".

(c) DEFINITION OF QUALIFIED BENEFICIARY MODIFIED IN REORGANIZATION CASES.—

(1) IRC AMENDMENT.—Section 162(k)(7)(B) of the Internal Revenue Code of 1986, as amended by section 1895(d)(7) of the Tax Reform Act of 1986, (relating to special rule for termination and reduced employment in definition of qualified beneficiary) is amended by adding at the end the following new clause:

"(iv) SPECIAL RULE FOR RETIREES AND WIDOWS.—In the case of a qualifying event described in paragraph (3)(F), the term 'qualified beneficiary' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

"(I) as the spouse of the covered employee,

"(II) as the dependent child of the employee, or

"(III) as the surviving spouse of the covered employee.".

(2) ERISA AMENDMENT.—Section 607(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) (relating to special rule for termination and reduced employment in definition of qualified beneficiary) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR RETIREES AND WIDOWS.—In the case of a qualifying event described in section 603(6), the term 'qualified beneficiary' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

"(i) as the spouse of the covered employee,

"(ii) as the dependent child of the employee, or

"(iii) as the surviving spouse of the covered employee.".

(d) NOTICE.—

(1) IRC AMENDMENT.—Subparagraphs (B) and (D)(i) of section 162(k)(6) of the Internal Revenue Code of 1986 (relating to notice requirements) are amended by striking "or (D)" each place it appears and inserting in lieu thereof "(D), or (F)".

(2) ERISA AMENDMENT.—Paragraphs (2) and (4)(A) of section 606 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166) (relating to notice requirements) are amended by striking "or (4)" each place it appears and inserting in lieu therof "(4), or (6)".

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(2) TREATMENT OF CERTAIN BANKRUPTCY PROCEEDINGS.—Notwithstanding paragraph (1), section 10001(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985, and section 10002(d) of such Act, the amendments made by this section and by sections 10001 and 10002 of such Act shall apply in the case of plan years ending during the 12-month period beginning July 1, 1986, but only with respect to—

(A) a qualifying event described in section 162(k)(3)(F) of the Internal Revenue Code of 1986 or section 603(6) of the Employee Retirement Income Security Act of 1974, and

(B) a qualifying event described in section 162(k)(3)(A) of the Internal Revenue Code of 1986 or section 603(1) of the Employee Retirement Income Security Act of 1974 relating to the death of a retired employee occurring after the date of the qualifying event described in subparagraph (A).

(3) TREATMENT OF CURRENT RETIREES.—Section 162(k)(3)(F) of the Internal Revenue Code of 1986 and section 603(6) of the Employee Retirement Income Security Act of 1974 apply to covered employees who retired before, on, or after the date of the enactment of this Act.

(4) NOTICE.—In the case of a qualifying event described in section 603(6) of the Employee Retirement Income Security Act of 1974 that occurred before the date of the enactment of this Act, the notice required under section 606(2) of such Act (and under

*'ENDMENT.—Section 607(3) of the Employee Re-
Security Act of 1974 (29 U.S.C. 1167(3)) (relat-
ile for termination and reduced employment in
alified beneficiary) is amended by adding at the
g new subparagraph:*
*'AL RULE FOR RETIREES AND WIDOWS.—In the
ualifying event described in section 603(6), the
fied beneficiary' includes a covered employee
'ired on or before the date of substantial elimi-
overage and any other individual who, on the
uch qualifying event, is a beneficiary under the*
*: the spouse of the covered employee,
s the dependent child of the employee, or
as the surviving spouse of the covered employ-*
*'MENT.—Subparagraphs (B) and (D)(i) of section
nternal Revenue Code of 1986 (relating to notice
e amended by striking "or (D)" each place it ap-
ng in lieu thereof "(D), or (F)".
ENDMENT.—Paragraphs (2) and (4)(A) of section
oyee Retirement Income Security Act of 1974 (29
ating to notice requirements) are amended by
each place it appears and inserting in lieu
".
;—
.—The amendments made by this section shall
included in title X of the Consolidated Omni-
nciliation Act of 1985.
' OF CERTAIN BANKRUPTCY PROCEEDINGS.—Not-
ragraph (1), section 10001(e) of the Consolidated
't Reconciliation Act of 1985, and section
Act, the amendments made by this section and
and 10002 of such Act shall apply in the case
'ing during the 12-month period beginning July
with respect to—
ifying event described in section 162(k)(3)(F) of
Revenue Code of 1986 or section 603(6) of the
tirement Income Security Act of 1974, and
ifying event described in section 162(k)(3)(A) of
Revenue Code of 1986 or section 603(1) of the
'tirement Income Security Act of 1974 relating
of a retired employee occurring after the date
'ying event described in subparagraph (A).
OF CURRENT RETIREES.—Section 162(k)(3)(F) of
'nue Code of 1986 and section 603(6) of the Em-
t Income Security Act of 1974 apply to covered
'tired before, on, or after the date of the enact-
: the case of a qualifying event described in sec-
Employee Retirement Income Security Act of
d before the date of the enactment of this Act,
'd under section 606(2) of such Act (and under*

section 162(k)(6)(B) of the Internal Revenue Code of 1986) with respect to such event shall be provided no later than 30 days after the date of the enactment of this Act.

And the Senate agree to the same.

From the Committee on the Budget, for consideration of the entire House bill and Senate amendment, except for revenue measures on which conferees from the Committee on Ways and Means have been appointed:

WILLIAM H. GRAY III,
MIKE LOWRY,
BUTLER DERRICK,
ED JENKINS,
CHET ATKINS
(for purposes of short title/table of contents, title VII, and section 6004 only),
DELBERT L. LATTA,
LYNN MARTIN,

From the Committee on the Budget, solely for consideration of those portions of the House bill and Senate amendment containing revenue measures on which conferees from the Committee on Ways and Means have been appointed:

ED JENKINS,

From the Committee on Agriculture, solely for consideration of title II of the House bill and title I and section 501 of the Senate amendment:

E DE LA GARZA,
ED JONES,
CHARLIE STENHOLM
(except for consideration of section 501 of the Senate amendment),
BERKLEY BEDELL
(solely for consideration of section 501 of the Senate amendment),
SID MORRISON,
STEVE GUNDERSON,

From the Committee on Appropriations, solely for consideration of sections 11001 and 11002 of the House bill and sections 665 and 1106 of the Senate amendment:

JAMIE L. WHITTEN,
VIC FAZIO,
SILVIO O. CONTE,

From the Committee on Banking, Finance and Urban Affairs, solely for the consideration of title III of the House bill, and title II of the Senate amendment:

FERNAND J. ST GERMAIN,
FRANK ANNUNZIO,
MARY ROSE OAKAR,
CHALMERS P. WYLIE,
STEWART B. MCKINNEY,
JIM LEACH,

OF FEDERAL PERCENTAGE OF AFDC EXPENDI-
F THE HOUSE BILL, SECTION 652 OF SENATE

P.L. 99-272, the Federal percentage was
er 1 and November 1 of each even-num-
ge applied to the two-year period begin-
er. P.L. 99-272 requires an annual rather
of the Federal percentage beginning in

al to an annual calculation of the Federal
middle of the two-year cycle and results in
s in FY 1987.
he Department of Health and Human
ed are: Arizona, Florida, Georgia, Maine,
w Hampshire, North Carolina, Ohio,
ina, South Dakota and Virginia.

es the biennial calculation of the Federal
lost funds in the shift to an annual cal-

1986.

t follows the House bill and the Senate

ATION OF CHILD SUPPORT ARREARAGES
OF SENATE AMENDMENT)

upport order can be modified only pro-
s of the modification do not take effect
ch it becomes final. Thus, only future
uld be affected. However, a number of
ort award to be retroactively modified.
administrative entity) has the author-
rages. Further, under the Uniform Re-
port Act (URESA), in interstate cases,
l parent's State may modify the child
l parent's State to the same extent the
e State that issued the order.

enforcement program established by
urity Act a new requirement which

States must meet to be in compliance with that program. To meet this new requirement, State laws relating to the enforcement of child support orders must prohibit changes in those orders which are effective on a retroactive basis. If the noncustodial parent's circumstances change because of unemployment, illness or another such reason, the amendment requires notification of the custodial parent and the court or entity which issued the child support order of this changed circumstances and his/her intent to have the child support order modified. No modification would be permitted before the date of this notification.

Effective date.—On enactment.

Conference agreement

Under the conference agreement, the House recedes to the Senate amendment, with an amendment which: (1) permits either parent to apply for modification; (2) clarifies the notice requirements; and (3) makes technical changes.

II. Medicare Provisions (Part A)

1. CHANGES IN THE PART A DEDUCTIBLE (SECTION 10201 OF HOUSE BILL; SECTION 603 OF SENATE AMENDMENT)

Present law

Medicare's inpatient hospital deductible must, be law, be revised each January. The deductible is revised based on a formula which reflects the average cost of a day of hospital care. The deductible was $400 in 1985, and is $492 in 1986. The Administration estimates that the deductible will increase to $572 in 1987.

The deductible is used in computing the coinsurance amount for post-hospital extended care services and in computing the monthly part A premium.

House bill

(a) Inpatient hospital deductible for 1987.—Sets the inpatient hospital deductible for 1987 at $500.

(b) Inpatient hospital deductible for years after 1987.—No provisions; that is, current law would prevail.

Effective date.—Applies to inpatient hospital services furnished in 1987.

Senate amendment

(a) Inpatient hospital deductible for 1987.—Sets the inpatient hospital deductible for 1987 at $520.

(b) Inpatient hospital deductible for years after 1987.—Sets the inpatient hospital deductible for any succeeding year at an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the same percentage that applies to PPS payment rates and adjusted to reflect changes in real case mix. Any amount so determined which is not a multiple of $4.00 shall be rounded to the nearest $4.00.

Effective date.—Applies to spells of illness beginning on or after January 1, 1987.

Conference agreement

(a) Inpatient hospital deductible for 1987.—The conference agreement includes the Senate amendment with modifications to clarify current law. The part A deductible for calendar year 1987 will be $520. In subsequent years the part A deductible will be adjusted by the applicable percentage increase (as defined in 1886(b)(3)(B)) for hospital payments under medicare adjusted to reflect changes in real case mix. The part A deductible would continue to be applied on a spell of illness basis.

Current law would be clarified to indicate that the deductible applicable to a hospital stay which falls into two calendar years would be the deductible in effect on the first day of the hospitalization Applicable cost sharing under part A would continue to be determined based on the annual deductible in effect for the year in which the cost sharing days are incurred Further, the conference agreement requires that the Secretary of Health and Human Services published within 30 days after enactment the new deductible and coinsurance rates for calendar year 1987.

(b) Inpatient hospital deductible for year after 1987.—The conference agreement includes the Senate amendment.

2. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES (SECTION 10202 OF HOUSE BILL; SECTION 601 SENATE AMENDMENT)

Present law

(a-c) Rate of Increase, Conforming Amendments, and Promulgation of New Rate.—The Social Security Amendments of 1938 (P.L. 98–21) authorized the Secretary to determine the rate of increase in the payment rates for hospitals included in the prospective payment system (PPS) for FY 1986 and thereafter; taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC).

HHS issued final rules on September 3, 1985, freezing the PPS payment rates for FY 1986. However, these rules were not implemented because of the enactment of emergency extension legislation which provided that the FY 1986 PPS rates would be frozen at FY 1985 levels through March 14, 1986.

COBRA continued the FY 1986 rate freeze until April 30, 1986, and provided for a rate of increase of ½ of 1 percent for the remainder of the Federal fiscal year for both PPS and PPS-exempt hospitals. In addition, for FY 1987 and FY 1988, it provided that the update factor may not exceed the rate of increase in the market basket idex.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the FY 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986.

In proposed rules issued June 3, 1986, HHS provided for an increase of 0.5 percent in the FY 1987 PPS rates and in the target amounts per discharge for PPS-exempt hospitals. In a July 2, 1986, letter to HCFA, ProPAC recommended a 2.2 percent increase in the FY 1987 PPS rates if capital is to be included into the prospec-

leductible for 1987.—The conference agree-
e amendment with modifications to clarify
deductible for calendar year 1987 will be
s the part A deductible will be adjusted by
e increase (as defined in 1886(b)3(B)) for
medicare adjusted to reflect changes in
A deductible would continue to be applied

larified to indicate that the deductible ap-
ay which falls into two calendar years
n effect on the first day of the hospitaliza-
ring under part A would continue to be
annual deductible in effect for the year in
ays are incurred. Further, the conference
he Secretary of Health and Human Serv-
days after enactment the new deductible
calendar year 1987.

eductible for year after 1987.—The confer-
he Senate amendment.

F INCREASE IN PAYMENTS FOR INPATIENT
TION 10202 OF HOUSE BILL; SECTION 601

Conforming Amendments, and Promulga-
ocial Security Amendments of 1938 (P.L.
retary to determine the rate of increase
ospitals included in the prospective pay-
1986 and thereafter; taking into account
e Prospective Payment Assessment Com-

on September 8, 1985, freezing the PPS
5. However, these rules were not imple-
actment of emergency extension legisla-
ie FY 1986 PPS rates would be frozen at
rch 14, 1986.
Y 1986 rate freeze until April 30, 1986,
increase of ½ of 1 percent for the re-
cal year for both PPS and PPS-exempt
FY 1987 and FY 1988, it provided that
ot exceed the rate of increase in the

l Emergency Deficit Control Act of 1985
Y 1986 Medicare payments to hospitals
ch 1, 1986.
June 3, 1986, HHS provided for an in-
FY 1987 PPS rates and in the target
PPS-exempt hospitals. In a July 2, 1986,
ecommended a 2.2 percent increase in
pital is to be included into the prospec-

tive payment system or a 1.9 percent increase without capital, a rate of increase for PPS-exempt children's hospitals of 3.2 percent, and a rate of increase for other PPS exempt hospitals and units of 3.5 percent.

(d) FY 1988 update recommendations.—The Prospective Payment Assessment Commission is required to issue a report to the Secretary on April 1 of each year with its recommendations on ways to update and improve the prospective payment system. The Secretary is required to promulgate proposed PPS regulations not later than June 1 and final PPS regulations not later than September 1.

(e) PPS-exempt update.—HHS has argued that a technical change in COBRA prohibits HHS from providing separate update factors for PPS and PPS-exempt hospitals.

(f) Outlier payments for small rural hospitals and sole community hospitals.—P.L. 98–21 provided for additional payments to PPS hospitals for "outliers"—cases with very long lengths of stay or extraordinarily high costs compared to most patients classified in the same DRG. The law requires that total outlier payments to all PPS hospitals be not less than 5 percent nor more than 6 percent of the total estimated Medicare prospective payments based on the DRG payment rates for the fiscal year.

COBRA required the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on rural hospitals (particularly on rural hospitals with fewer than 100 beds).

(g) Computing urban and rural averages.—P.L. 98–21 provided that PPS hospitals are paid, in part, on the basis of Federal regional and national standardized amounts per discharge. The law requires the calculation of separate urban and rural standardized amounts for each of the nine census regions and for the nation. These standardized amounts represent the urban or rural operating cost per discharge in the base year cost data (1981), averaged across all hospitals in the region (or nation) and updated to the year of payment. In this calculation, the average operating cost per discharge for each hospital is treated the same as the cost per discharge of any other hospital, regardless of how many Medicare discharges the hospital had during the base year. This results in amounts that represent the operating cost per discharge for the average hospital (rather than the average Medicare discharge).

(h) Regional referral centers.—PPS hospitals may apply for designation as a regional referral center. In order to qualify, hospitals must meet criteria based on bed size and location, or criteria based on case-mix, admission volume, or patient referrals. Hospitals meeting these criteria are paid prospective payments based on the applicable urban payment rates, rather than the rural rates, and adjusted by the hospital's area wage index.

Under regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period.

House bill

(a) Rate of increase.—Increases the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals by 1.0 percent and increases the FY 1988 payment rate by the market basket increase minus 2.0 percent.

(b) Conforming amendments.—Provides for conforming amendments.

(c) Promulgation of new rate.—Requires the Secretary to republish in the Federal Register the determination of the percent increase which will apply for FY 1987, taking into account the amendments made by this section.

(d) FY 1988 update recommendations.—Requires the Secretary to submit a report to Congress by April 1, 1987, providing a documented recommendation on what the Secretary believes the update factor should be for FY 1988.

(e) PPS-exempt update.—Provides that PPS-exempt hospitals and units may receive a separate update factor from PPS hospitals.

(f) Outlier payments for small rural hospitals and sole community hospitals—No provision.

(g) Computing urban and rural averages.—No provision.

(h) Regional referral centers.—Extends the 3-year period granted for regional referral centers status to 4 years. After the 4th year, the hospital would be required to demonstrate, that it continues to meet the criteria. See also item 7(b) (section 10207 of House bill).

Effective date.—Applies rate of increase provision to hospital cost reporting periods beginning on or after October 1, 1986. For the Federal portion of the PPS payment rates, the rate of increase applies to discharges occurring on or after October 1, 1986. Conforming amendments are effective upon enactment. The promulgation of new rates provision requires the Secretary to republish the rate determination in the Federal Register within 30 days after the date of enactment of this Act but in no case later than October 1, 1986, without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.

Senate amendment

(a) Rate of increase.—Increases the FY 1987 payment rates for PPS hospitals and PPS hospitals by 1.3 percent. The marketbasket rate of increase limitation is extended to payment rates for FY 1989.

(b) Conforming amendments.—No provision.

(c) Promulgation of new rate.—No provision.

(d) FY 1988 update recommendations.—No provision

(e) PPS-exempt update.—No provision.

(f) Outlier payments for small rural hospitals and sole community hospitals.—Requires the total amount of outlier payments for sole community hospitals with average occupancies of 50 beds or fewer, and small rural hospitals (defined as a hospital in a rural area with fewer than 50 beds) to be not less than 5 percent nor more than 6 percent of the total payments based on DRG prospective payment rates projected or estimated to be made to such hospitals in a given year.

Requires the Prospective Payment Assessment Commission to include in its annual report an analysis of the appropriate thresholds for outliers.

Requires the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on sole community providers.

'ments.—Provides for conforming amend-

ıt *rate.*—Requires the Secretary to repub-ster the determination of the percent in- for FY 1987, taking into account the s section.

ommendations.—Requires the Secretary to ress by April 1, 1987, providing a docu-on what the Secretary believes the update 988.

—Provides that PPS-exempt hospitals and ate update factor from PPS hospitals.

small rural hospitals and sole community

d rural averages.—No provision.

nters.—Extends the 3-year period granted ers status to 4 years. After the 4th year, uired to demonstrate, that it continues to so item 7(b) (section 10207 of House bill). rate of increase provision to hospital cost ng on or after October 1, 1986. For the 'S payment rates. the rate of increase ap-ing on or after October 1, 1986. Conform-ctive upon enactment. The promulgation quires the Secretary to republish the rate ral Register within 30 days after the date out in no case later than October 1, 1986, visions of chapter 5 (Administrative Pro-ernment Organization and Employees),

ıcreases the FY 1987 payment rates for spitals by 1.3 percent. The marketbasket n is extended to payment rates for FY

ents.—No provision.

rate.—No provision.

nmendations.—No provision

No provision.

small rural hospitals and sole community

otal amount of outlier payments for sole average occupancies of 50 beds or fewer, defined as a hospital in a rural area with not less than 5 percent nor more than 6 ents based on DRG prospective payment d to be made to such hospitals in a given

Payment Assessment Commission to in-an analysis of the appropriate thresholds

o report to Congress no later than Janu-t of outlier and patient transfer policies rs.

(g) Computing urban and rural averages.—The current formula used to calculate the separate average standardized payment amounts for urban and rural hospitals under PPS would be changed to be based on the number of patients discharged rather than the number of hospitals. This would result in amounts that represent the operating cost per discharge for the average patient as opposed to the average hospital.

(h) Regional referral centers.—Hospitals designated as regional referral centers as of the date of enactment shall retain that designation for all hospital cost reporting periods beginning before October 1, 1989.

Provides that to be classified as a regional referral center, a rural hospital must (1) have a case mix equal to or greater than the median case mix for urban hospitals located in the same census region or the Nation (other than hospitals with approved teaching programs); (2) have 5,000 or more discharges a year (or in the case of a rural osteopathic hospital, meets the criterion established by the Secretary for the annual number of discharges); and (3) meet any other criteria established by the Secretary.

Effective date.—Applies rate of increase provision for PPS hospitals to discharges occurring on or after October 1, 1986 (for the Federal portion of the rate), and to discharges occurring in hospital cost reporting periods beginning on or after October 1, 1986 (for the hospital-specific portion of the rate). The rate of increase provision for PPS-exempt hospitals applies to hospital cost reporting periods beginning on or after October 1, 1986. The outlier payments for small rural hospitals and sole community hospitals provision (except the reports required from ProPAC or the Secretary) apply to discharges occurring after September 30, 1986, and before the first October 1 that is more than 270 days after the date on which the Secretary submits the report on outliers required by COBRA. The computing urban and rural averages provision is effective for discharges occurring on or after October 1, 1986. Hospitals which are regional referral centers on the date of enactment shall retain that status for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Conference agreement

(a) Rate of increase.—The conference agreement includes the Senate amendment with modifications. Effective October 1, 1986, the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals will be increased by 1.15 percent. For FY 1988 the Secretary is required to increase the payment rates for PPS hospitals and PPS-exempt hospitals by an update factor equal to the market basket increase (as defined in Section 1886(b)(3)(B) of the Social Security Act), minus 2 percentage points.

The Secretary of Health and Human Services will be required to adjust the diagnosis-related group (DRG) categories and recalibrate the DRG relative weights annually, beginning in FY 1988, to ensure that the weights reflect the use of new technologies and other practice patttern changes affecting the relative use of hospital resources among DRG categories.

The conference agreement requires that the Secretary publish the June 1 proposed FY 1988 medicare prospective payment regula-

tion—providing for the mandated update factor, adjusting the diagnosis-related group (DRG) categories, recalibrating the DRG relative weights, and making other adjustments as appropriate and within the scope of the law. The final regulation would be published by September 1, 1987, for implementation October 1, 1987.

(b) Conforming amendments.—The conference agreement includes the House provision.

(c) Promulgation of new rate.—The conference agreement includes the House provision with an amendment requiring promulgation of the new rates no later than 30 days after enactment. Provisions of chapter 5 of title 5 of the U.S. Code would be waived.

(d) FY 1988 update recommendations.—The conference agreement includes the House provision with an amendment to require that the Secretary provide a report with recommendations on the projected PPS and PPS-exempt update factors on April 1, 1987 and annually thereafter on March 1. The conference agreement requires that the Secretary, for the FY 1988 update factor provide a report and a documented recommendation to Congress by Arpil 1, 1987, on what the Secretary would recommend for the FY 1988 update factor. Congress will review this report, along with the report of the Prospective Payment Assessment Commission, and make a determination as to what, if any, adjustments should be made to the FY 1988 update factor (established under this legislation at the projected rate of increase in the hospital market basket index minus two percentage points). The Prospective Payment Assessment Commission's annual report submitted to the Secretary as required in Section 1886(e)(4) would be due annually on March 1, effective with the 1988 (FY 1989) annual report. The annual promulgation of the proposed prospective payment regulations currently required to be published no later than June 1 of a year would be moved to no later than May 1, beginning with the 1988 (the FY 1989) update factor. The purpose of requiring submission of the report on March 1 of a year, and promulgation of the proposed regulation on May 1 of a year, is to allow for a sixty day public comment period.

(e) PPS-exempt update.—The conference agreement includes the House provision.

(f) Outlier payments for small rural hospitals and sole community hospitals.—The conference agreement includes the Senate amendment with a modification. Effective October 1, 1986, a separate urban and separate rural set-aside factor for outliers would be established. The Federal standardized payment amount for each hospital group (i.e., urban hospitals and rural hospitals) would be reduced by the amount necessary to offset the projected outlier payments to that group in the forthcoming fiscal year. For fiscal year 1987 the standardized amount will be reduced by 5 percent to account for outlier payments. The rural standardized payment amounts will be increased by the dollar amount difference between the 5 percent previous reduction and the estimated rural outlier payments for fiscal year 1987 (most recent estimates are that outlier payments to rural hospitals will account for 3 percent of their total payments). The urban standardized amounts will be reduced by an equivalent dollar amount so as to result in the same level of total system payments. The outlier thresholds and standards used

ndated update factor, adjusting the diag- categories, recalibrating the DRG rela- other adjustments as appropriate and w. The final regulation would be pub- 87, for implementation October 1, 1987. ients.—The conference agreement in-

· *rate.*—The conference agreement in- with an amendment requiring promul- later than 30 days after enactment. Pro- 5 of the U.S. Code would be waived.

ommendations.—The conference agree- rovision with an amendment to require a report with recommendations on the mpt update factors on April 1, 1987 and arch 1. The conference agreement re- or the FY 1988 update factor provide a ecommendation to Congress by Arpil 1, ry would recommend for the FY 1988 ll review this report, along with the Payment Assessment Commission, and o what, if any, adjustments should be e factor (established under this legisla- increase in the hospital market basket points). The Prospective Payment As- ual report submitted to the Secretary 1X4) would be due annually on March 1, 1989) annual report. The annual pro- prospective payment regulations cur- shed no later than June 1 of a year than May 1, beginning with the 1988 The purpose of requiring submission of ear, and promulgation of the proposed ear, is to allow for a sixty day public

he conference agreement includes the

all rural hospitals and sole community greement includes the Senate amend- Effective October 1, 1986, a separate t-aside factor for outliers would be es- ardized payment amount for each hos- itals and rural hospitals) would be re- ary to offset the projected outlier pay- orthcoming fiscal year. For fiscal year nt will be reduced by 5 percent to ac- s. The rural standardized payment · the dollar amount difference between ction and the estimated rural outlier 7 (most recent estimates are that out- als will account for 3 percent of their standardized amounts will be reduced nt so as to result in the same level of outlier thresholds and standards used

for making additional payments shall be the same as those in effect on October 1, 1986. The conferees expect that the outlier adjustments will continue to be made as the last adjustment to the standardized payment amounts (following the budget neutral restandardization required by section 9104 of P.L. 99-272).

In addition the conference agreement extends for two years the provision of section 1886(dX5XCXii) of the Social Security Act which provides for an additional payment to sole community hospitals that experience a 5% decrease in volume.

(g) Computing urban and rural averages.—The conference agreement includes the Senate amendment with a modification to make the effective date October 1, 1987.

(h) Regional referral centers.—The conference agreement includes the Senate amendment with a modification. The Secretary is required to extend the current 3-year period of regional referral center designation for 3 additional years for hospitals so designated on the date of enactment. The provision is further amended to require that in establishing the discharge threshold for eligibility for regional referral center status that the threshold be the lesser of 5,000 discharges or the median number of discharges in urban hospitals in the region in which the hospital is located.

In addition the conference agreement requires the Secretary to conduct a secondary rural referral center demonstration at Lake Region Hospital and Nursing Home in Fergus Falls, Minnesota.

3. LIMITATION ON PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES OF DRG HOSPITAL UNDER MEDICARE (SECTION 10203 OF HOUSE BILL; SECTION 602 OF SENATE AMENDMENT)

Present law

The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system (PPS) for making payments on a per discharge basis to hospitals for the operating costs of inpatient services provided to Medicare beneficiaries. Hospital capital-related costs for inpatient services (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from the definition of operating cost for PPS and are reimbursed on a reasonable cost basis. This exclusion from the operating costs was to expire on October 1, 1986, but was extended until October 1, 1987, by the Urgent Supplemental Appropriations Act (P.L. 99-349).

Current law provides that if Congress did not enact legislation by October 1, 1987, to include capital-related costs under PPS, Medicare payment for capital costs would be prohibited unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure.

House bill

(a) Payment limitation.—Requires the Secretary to cap the aggregate amount of PPS hospital capital-related payments. The cap for FY 1987 shall be the aggregate amount of hospital capital payments in 1986 as estimated by the Secretary plus 10 percent; for FY 1988 will be limited to the aggregate amount of hospital capital

payments in FY 1986 plus 20 percent; and for FY 1989 will be limited to the aggregate amount of hospital capital payments in FY 1986 plus 30 percent. The FY 1986 base and the allowable costs reimbursed will be adjusted to reflect the phasing-out of payments for return on equity capital.

The Secretary would be permitted to adjust the FY 1986 base in each of the following fiscal years based on the most recent available data.

(b) Publication of capital reduction percentage.—If the Secretary determines the target limits will be exceeded, the Secretary would be required to determine and publish the appropriate capital reduction percentage for each fiscal year required to maintain payments within the limit. The percent would be based upon the best available information before the beginning of the fiscal year involved.

Requires the Secretary to publish in the Federal Register, no later than 30 days after the date of the enactment of this Act or, if earlier, by October 1, 1986, the capital reduction percentage for FY 1987. In promulgating the percentage for FY 1987, the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code, and of chapter 35 (Programs for Older Americans) of title 41 (Public Contracts), United States Code, shall not apply.

(c) No administrative or judicial review.—Prohibits administrative or judicial review of the capital reduction percentage.

(d) Interim and final payments.—Interim and final payments would be based on the percentage determined by the Secretary for portions of cost reporting periods occurring during the fiscal year.

(e) Sole community hospitals.—No provision.

Effective date.—Applies to payments for capital-related costs attributable to portions of cost reporting periods occurring on or after October 1, 1986.

Senate amendment

(a) Payment limitation.—Requires the Secretary to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3 percent for cost reporting period beginning on or after October 1, 1986, and before October 1, 1987; by 5 percent for cost reporting periods beginning on or after October 1, 1987, and before October 1, 1988; and by 6 percent for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1989.

(b) Publication of capital reduction percentage.—No provision.

(c) No administrative or judicial review.—No provision.

(d) Interim and final payments.—No provision.

(e) Sole community hospitals.—Does not apply to the capital-related costs of sole community hospitals.

Effective date.—Cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

Conference agreement

(a) Payment limitation.—The conference agreement includes the Senate amendment with modifications. The Secretary is required to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3.5

is 20 percent; and for FY 1989 will be lim-
nount of hospital capital payments in FY
e FY 1986 base and the allowable costs re-
d to reflect the phasing-out of payments
tal.

e permitted to adjust the FY 1986 base in
cal years based on the most recent avail-

al reduction percentage.—If the Secretary
nits will be exceeded, the Secretary would
and publish the appropriate capital reduc-
fiscal year required to maintain payments
rcent would be based upon the best avail-
the beginning of the fiscal year involved
to publish in the Federal Register, no
he date of the enactment of this Act or, if
6, the capital reduction percentage for FY
e percentage for FY 1987, the provisions of
Procedures) of title 5 (Government Orga-
United States Code, and of chapter 35
nericans) of title 41 (Public Contracts),
not apply.

r judicial review.—Prohibits administra-
he capital reduction percentage.

payments.—Interim and final payments
rcentage determined by the Secretary for
periods occurring during the fiscal year.

itals.—No provision.

to payments for capital-related costs at-
ost reporting periods occurring on or after

—Requires the Secretary to reduce the
ed payments to PPS hospitals otherwise
ble under current law, by 3 percent for
inning on or after October 1, 1986, and
5 percent for cost reporting periods be-
r 1, 1987, and before October 1, 1988; and
rting periods beginning on or after Octo-
tober 1, 1989.

reduction percentage.—No provision.

judicial review.—No provision.

ments.—No provision.

itals.—Does not apply to the capital-relat-
hospitals.

orting periods beginning on or after Oc-
ctober 1, 1989.

—The conference agreement includes the
odifications. The Secretary is required to
pital-related payments to PPS hospitals
e reasonable under current law, by 3.5

percent for portions of cost-reporting periods occurring in FY 1987; by 7 percent for FY 1988; and by 10 percent for FY 1989. The conferees expect that all capital costs (including return on equity payments and funded depreciation offsets) will be included in the base for calculating the payment reductions. The conferees anticipate that the reductions will be implemented on a pro rata monthly basis.

It is the intent of the conferees that the Congress reconsider the issue of payment for capital-related costs to hospitals under medicare in the forthcoming year. The conferees anticipate that, during this period, the Congress will develop a legislative proposal to incorporate capital payments under medicare into the prospective payment system. The conferees intend that this proposal will continue cost-related reimbursement for capital-related financial obligations, or enforceable agreements entered into, in the past by hospitals. The Conferees expressly indicate that at this time there be no specific date as to when a capital-related cost would be considered "obligated" for purposes of a "grandfather" clause.

If the Congress does not exercise its prerogative to legislate on this matter, the conference agreement recognizes that the Secretary has the authority, beginning in FY 1988, to incorporate capital-related costs into the prospective payment system. In promulgating any regulations which would incorporate capital payments into the prospective payment system, the Secretary shall ensure that the medicare total aggregate payments for capital under the new prospective payment system shall be neither more nor less than the payments that would otherwise have been provided under this section (i.e. be "budget neutral"). The Secretary is prohibited, between September 1, 1986 and September 1, 1987, from promulgating final regulations that change the methodolgy for computing the amount of payment for capital-related costs under title XVIII of the Social Security Act.

Further, the conference agreement provides a technical amendment to clarify that if the Secretary chooses not to incorporate capital into the prospective payment system, cost reimbursement would continue for capital-related costs, subject to the limitations in the conference agreement.

(b) Publication of capital reduction percentage.—The conference agreement does not include the House provision.

(c) Administrative or judicial review.—The conference agreement does not include the House provision.

(d) Interim and final payments.—The conference agreement does not include the House provision.

(e) Sole community hospitals.—The conference agreement includes the Senate amendment exempting, for three years, sole community providers from capital-related payment reductions and further would exempt, for three years, sole-community providers from a prospective payment system for capital if provided by the Secretary under regulations.

4. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER DRG PROSPECTIVE PAYMENT SYSTEM (SECTION 10204 OF HOUSE BILL)

Present law

Hospitals outside the 50 States and the District of Columbia are excluded by law from the prospective payment system (PPS) and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits.

The Secretary is required to report on methods of making payments to hospitals in the territories, including Puerto Rico, under a prospective payment system by April 1, 1984. The report has not yet been submitted.

House bill

(a) In general.—Requires the Secretary to include eligible Puerto Rico hospitals in PPS. A hospital would be included in PPS if it is located in Puerto Rico and otherwise would be a PPS hospital if it were located in one of the 50 States.

(b) Payment rate.—Establishes payment amounts based on the sum of: (1) 75 percent of the Puerto Rico adjusted standardized payment amount; and (2) 25 percent of the national adjusted standardized payment amount.

(c) Base used to establish Puerto Rico amount.—Requires the Secretary to determine each hospital's target amount per discharge (under section 223) for hospital cost reporting periods beginning in FY 1986.

(d) Updating the base.—Requires the Secretary to increase the hospital's target amount per discharge by the applicable percentage increase for FY 1987.

(e) Standardizing the amount.—Requires the Secretary to standardize this amount by: (1) excluding an estimate of indirect medical education costs; (2) adjusting for variations in the Puerto Rico average hospital wage level; and (3) adjusting for variations in case mix among hospitals.

(f) Urban and rural hospitals.—Requires the Secretary to calculate an average standardized amount for urban and for rural hospitals.

(g) Additional reductions.—Requires the Secretary to reduce the Puerto Rico standardized amounts by a proportion equal to the proportion (estimated by the Secretary) that outlier payments and disproportionate share payments represent of total Puerto Rico payments.

(h) Puerto Rico prospective payment rate.—Requires the Secretary to establish Puerto Rico urban and rural prospective payment rates for discharges within a DRG, equal to the urban or rural average standardized amount, with the additional reductions, multiplied by the weighting factor for that diagnosis related group.

(i) Area wage adjustment.—Requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of hospital costs attributable to wages and wage-related costs for area differences in hospitals wage levels by a factor (established by the Secretary) reflecting the relative wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

50 States and the District of Columbia are he prospective payment system (PPS) and of reasonable costs, subject to the TEFRA

uired to report on methods of making pay- territories, including Puerto Rico, under a stem by April 1, 1984. The report has not

res the Secretary to include eligible Puerto hospital would be included in PPS if it is nd otherwise would be a PPS hospital if it ne 50 States.

tablishes payment amounts based on the the Puerto Rico adjusted standardized pay- percent of the national adjusted standard-

sh Puerto Rico amount.—Requires the Sec- ch hospital's target amount per discharge ospital cost reporting periods beginning in

.—Requires the Secretary to increase the t per discharge by the applicable percent-

amount.—Requires the Secretary to stand- excluding an estimate of indirect medical ting for variations in the Puerto Rico aver- and (3) adjusting for variations in case mix

ospitals.—Requires the Secretary to calcu- lized amount for urban and for rural hospi-

ons.—Requires the Secretary to reduce the d amounts by a proportion equal to the pro- e Secretary) that outlier payments and dis- ments represent of total Puerto Rico pay-

tive payment rate.—Requires the Secretary urban and rural prospective payment rates DRG, equal to the urban or rural average th the additional reductions, multiplied by that diagnosis related group.

ent.—Requires the Secretary to adjust the by the Secretary from time to time) of hos- o wages and wage-related costs for area dif- ge levels by a factor (established by the relative wage level in the geographic area ed to the Puerto Rican average hospital

(j) FY 1988 and beyond.—Requires the Secretary, for each hospital discharge after FY 1987, to compute the Puerto Rico adjusted DRG prospective payment rate by: (1) using the hospital's respective urban or rural average standardized amount as computed (in (f) above) for the previous fiscal year; (2) increasing this amount by the applicable percentage increase; and (3) by carrying out the steps described in (e) through (i) above.

(k) National adjusted standardized payment amount.—Requires the Secretary to determine the average of the national adjusted standardized payment amounts for urban and for rural hospitals.

(l) Additional payments.—Provides for payment to Puerto Rico PPS hospitals in the same manner and to the same extent as they apply to other PPS hospitals for the following: outlier payments except that the total amount of outlier payments to Puerto Rico hospitals may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made for Puerto Rico hospitals for discharges in that year), payments for indirect medical education costs (expect that the calculation would conform to Puerto Rico's payment methodology), exceptions and adjustments, payments for costs of certified registered nurse anesthetists, and disproportionate share payments (except that the calculation would conform to Puerto Rico's payment methodology).

(m) Conforming amendments.—Provides for conforming amendments.

(n) No restandardization of national levels to reflect inclusion of Puerto Rico.—Prohibits the Secretary from restandardizing or otherwise adjusting the national DRG prospective payment rates to take into account Puerto Rico's inclusion into the prospective payment system.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1986. The Secretary is required to issue regulations no later than October 1, 1986, to implement such amendments without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.

Senate amendment

No provision.

Conference agreement

(a) In general.—The conference agreement includes the House provision with a modification to include eligible Puerto Rico hospitals into the medicare prospective payment system effective for discharges occurring on or after October 1, 1987.

(b) Payment rate.—The conference agreement includes the House provision with technical corrections.

(c) Base used to establish Puerto Rico amount.—The conference agreement includes the House provision with a modification moving the effective date to October 1, 1987.

(d) Updating the base.—The conference agreement includes the House provision with a modification to move the effective date forward by one year and to make other technical amendments.

(e) Standardizing the amount.—The conference agreement includes the House provision with technical amendments.

(f) Urban and rural hospitals.—The conference agreement includes the House provision with a modification to require urban and rural standardized amounts to be discharge weighted (as opposed to hospital weighted).

(g) Additional reductions.—The conference agreement includes the House provision with technical clarifications.

(h) Puerto Rico prospective payment rate.—The conference agreement includes the House provision with technical clarifications.

(i) Area wage adjustment.—The conference agreement includes the House provision with technical amendments.

(j) FY 1988 and beyond.—The conference agreement includes the House provision.

(k) National adjusted standardized payment amount.—The conference agreement includes the House provision with a modification to require urban and rural standardized amounts to be discharge weighted (as opposed to hospital weighted).

(l) Additional payments.—The conference agreement includes the House provision with a modification to reduce the Federal standardized payment amount for Puerto Rico (i.e., separately for urban hospitals and for rural hospitals) by the amount necessary to offset the projected outlier payments to each subgroup of hospitals in Puerto Rico in the forthcoming fiscal year.

(m) Conforming amendments.—The conference agreement includes the House provision.

(n) No restandardization of national levels to reflect inclusion of Puerto Rico.—The conference agreement includes the House provision with a modification to require that the Secretary reduce the national and regional standardized payment amounts by the proportion necessary to assure that aggregate payments to PPS hospitals (including hospitals in Puerto Rico) in FY 1988 are neither greater nor less than the aggregate payments that would have been made to such hospitals under prior law (i.e., this section must be "budget neutral").

5. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES (SECTION 10205 OF HOUSE BILL; SECTIONS 604 AND 614 OF SENATE AMENDMENT)

Present law

(a) Refinement of Prospective Payment System.—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG.

(b) Requiring Notice of Hospital Discharge Rights.—On February 24, 1986, the Secretary instructed hospitals to provide Medicare inpatients with a notice explaining hospital discharge procedures under PPS and patients' rights to appeal discharge decisions. There is no statutory requirement that a statement of patient rights be distributed.

ospitals.—The conference agreement in-
on with a modification to require urban
mounts to be discharge weighted (as op-
).

ns.—The conference agreement includes
technical clarifications.

ive payment rate.—The conference agree-
provision with technical clarifications.

nt.—The conference agreement includes
technical amendments.

—The conference agreement includes the

tandardized payment amount.—The con-
les the House provision with a modifica-
d rural standardized amounts to be dis-
ed to hospital weighted).

.—The conference agreement includes the
nodification to reduce the Federal stand-
for Puerto Rico (i.e., separately for urban
ospitals) by the amount necessary to offset
ments to each subgroup of hospitals in
oming fiscal year.

dments.—The conference agreement in-
n.

n of national levels to reflect inclusion of
ence agreement includes the House provi-
to require that the Secretary reduce the
andardized payment amounts by the pro-
re that aggregate payments to PPS hospi-
in Puerto Rico) in FY 1988 are neither
ne aggregate payments that would have
als under prior law (i.e., this section must

F CARE WITH RESPECT TO PART A SERVICES
'SE BILL; SECTIONS 604 AND 614 OF SENATE

ospective Payment System.—Under Medi-
nt system (PPS) hospitals are paid a prede-
a patient's diagnosis-related group (DRG)
it is classified into one of 468 DRGs based
agnosis, secondary diagnosis, primary pro-
ge status. Payment rates for each DRG re-
providing care to patients classified in the

Hospital Discharge Rights.—On February
nstructed hospitals to provide Medicare in-
explaining hospital discharge procedures
rights to appeal discharge decisions. There
ient that a statement of patient rights be

(c) Requiring Hospitals to Provide Discharge Planning Process.—By regulation, hospitals participating in Medicare must have a discharge planning program to facilitate the provision of follow-up care.

(d) Review of Standards for Medicare Conditions of Participation for Assuring Quality of Inpatient Hospital Services.—For a hospital to be eligible for Medicare reimbursement, the hospital must be in compliance with Medicare's conditions of participation for hospitals as set forth in subchapter B of title 42 of the Code of Federal Regulations or must be accredited by a national accreditation body, such as the Joint Commission on Accreditation of Hospitals.

(e) Study of Payment for Administratively Necessary Days.—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG. No special provision is made for separate payment for "administratively necessary days." An administratively necessary day is a day of continued inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility.

(f) Continuing Waiver of Liability or SNFs, Home Health Agencies, and Hospice Programs.—Under waiver of liability, payment may be made for services which are not covered because they were not reasonable and necessary or were for custodial care if neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered for these reasons. By regulation, a home health agency is presumed to meet this test if its denial rate on claims for services is 2.5 percent or less. A SNF is presumed to meet the test if its denial rate is 5.0 percent or less. Hospice providers are not eligible for a favorable presumption.

Final regulations published February 21, 1986, eliminated the favorable presumption of the waiver of liability. Payment for noncovered services would have continued on a case-by-case basis. However, COBRA maintained the favorable presumption criteria for SNFs and home health agencies. As a result of the law, the favorable presumption will be continued until October 7, 1988, for SNF services. The favorable presumption for home health services will be continued until 12 months after claims processing for home health agencies has been consolidated under 10 regional intermediaries.

(g) Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services.—Beneficiaries who are homebound and require skilled nursing services on an intermittent basis or physical, occupational, or speech therapy are eligible for home health services. Program guidelines provide fiscal intermediaries and home health agencies with information and guidance about coverage determinations for patients who are "homebound" or whether skilled nursing and home health aide services are "intermittent." The current waiver of liability protection does not apply to noncovered home health services if the reason for the

denial is because the patient was determined not to be confined to his home or not to need skilled nursing care on other than an intermittent basis. Denials of these kinds are often referred to as technical denials.

(h) Development of Uniform Needs Assessment Instrument.—There is no comparable requirement in current law.

(i) Expedited Review by Fiscal Intermediaries.—Claims for skilled nursing facility, home health services, and hospice care services generally are reviewed on a retrospective basis after the services are provided. Standards for timeliness in claims submission and review are not provided in present law.

(j) Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care.—The Secretary is required to report on the impact of the prospective payment methodology for inpatient hospital services, due annually at the end of each year for 1984 through 1987.

(k) Prior Authorization Demonstration Project.—Medicare fiscal intermediaries have responsibility for deciding whether payment will be made for services provided by home health agencies and SNFs. Generally, these payment decisions are made on a retrospective basis after services are provided.

House bill

(a) Refinement of prospective payment system.—

(1) Development of legislative proposal.—Requires the Secretary to submit to Congress a specific legislative proposal to improve the classification and payment system under PPS (including the system for payment of outliers) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions.

(2) Accounting for severity of illness.—Requires the Secretary, in developing the proposal, to account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) Deadline.—Requires the proposal be submitted to Congress by no later than 2 years after the date of enactment.

Effective date.—Enactment.

(b) Requiring notice of hospital discharge rights.—Requires hospitals to provide to each beneficiary (or to a legally responsible person acting on the beneficiary's behalf), at or about the time of the beneficiary's admission as an inpatient, a written statement which explains (1) the beneficiary's rights to Medicare benefits for inpatient hospital services and for post-hospital services, (2) the circumstances under which the beneficiary will and will not be liable for charges for a continued hospital stay, (3) the beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and (4) the beneficiary's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides any additional information as the Secretary may specify.

Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies

was determined not to be confined to
illed nursing care on other than an
these kinds are often referred to as

rm Needs Assessment Instrument.—
ement in current law.

al Intermediaries.—Claims for skilled
services, and hospice care services
retrospective basis after the services
timeliness in claims submission and
sent law.

ports on Prospective Payment System
t-Hospital Care.—The Secretary is re-
of the prospective payment method-
ervices, due annually at the end of
87.

nonstration Project.—Medicare fiscal
bility for deciding whether payment
vided by home health agencies and
nt decisions are made on a retrospec-
vided.

payment system.—
ative proposal.—Requires the Secre-
a specific legislative proposal to im-
id payment system under PPS (in-
rment of outliers) in order to assure
ent per discharge approximates the
ary care provided in an efficient
ents or classes of patients with simi-

illness.—Requires the Secretary, in
ount for variations in severity of ill-
h are not adequately accounted for
d payment system.
the proposal be submitted to Con-
ars after the date of enactment.

al discharge rights.—Requires hospi-
iciary (or to a legally responsible
y's behalf), at or about the time of
an inpatient, a written statement
ary's rights to Medicare benefits for
for post-hospital services, (2) the cir-
neficiary will and will not be liable
pital stay, (3) the beneficiary's right
r continued inpatient hospital serv-
s to initiate such an appeal, and (4)
yment for services if such a denial
and which provides any additional
y specify.
Secretary to first prescribe the lan-
fter the date of enactment. Applies

to admissions to hospitals occurring on such date as the Secretary shall provide, but no later than 60 days after the date such language is first prescribed.

(c) Requiring hospitals to provide discharge planning process.—

(1) Requirement as a condition of participation.—Requires hospitals as a condition of participation for Medicare to have a discharge planning process.

(2) Discharge planning process defined.—Considers a discharge planning process sufficient if it is applicable to services furnished by the hospital to Medicare beneficiaries and if it meets the guidelines and standards established by the Secretary.

Requires the Secretary to develop these guidelines and standards in order to ensure a timely and smooth transition to the most appropriate type of setting for post-hospital or rehabilitative care. These guidelines and standards must include the following: (a) the hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning; (b) the hospital must provide a discharge planning evaluation for the identified patients and for other patients upon the request of the patient, patient's representative, or patient's physician; (c) any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge; (d) a discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services; (e) the discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative); (f) upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient; (g) any such discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(3) Effect on accreditation.—Provides that the requirement of discharge planning may not be satisfied by accreditation of the hospital accreditation body action pursuant to section 1865 of the Social Security Act unless the Secretary determines that the discharge planning standards of the accreditation body are at least equivalent to the standards required under this provision.

Effective date.—Applies as of one year after the date of enactment.

(d) Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.—Requires the Secretary to arrange for a study of the adequacy of the standards used for hospitals, for the purposes of meeting Medicare's conditions of participation in assuring the quality of services furnished in hospitals. Requires the Secretary to report to Congress on the results of the study by no later than 2 years after the date of enactment.

Effective date.—Enactment.

64-554 O - 86 - 10

(e) Study of payment for administratively necessary days.—

(1) In general.—Requires the Secretary to conduct a study to determine whether a payment should be made (in a budget-neutral way for PPS hospitals) to a hospital for administratively necessary days, separate from the DRG and outliner payments.

(2) Administratively necessary days defined.—Defines an "administratively necessary day" as a day of continued inpatient hospital stay, for a part A beneficiary, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(3) Consideration in conducting study.—Requires the Secretary, in conducting the study, to consider the need for such a payment to minimize the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and difficulties resulting from the source of payment for such care.

Requires the Secretary, in conducting the study, to consider the need for a payment to minimize the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility.

Requires the Secretary, in conducting the study, to consider the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) Report on study.—Requires the Secretary to report to Congress on the results of the study no later than January 1, 1988.

Effective date.—Enactment.

(f) Continuing waiver of liability for SNFs, home health agencies, and hospice programs.—Continues the favorable presumption of waiver of liability for SNFs and home health agencies, and establishes a favorable presumption for hospices having 2.5 percent or fewer claims denied on the basis of care not being reasonable and necessary or determined to be custodial in nature.

Requires the Secretary to report annually to Congress on (1) the frequency and distribution of denials because care was not reasonable and necessary or was custodial; and (2) other information needed to evalute the appropriateness of denial rates established for a favorable presumption.

Effective date.—For hospices, effective for care furnished on or after the first day of the first month that begins at least 6 months after date of enactment and before October 1, 1989. For SNFs and home health agencies, effective for services furnished on or after date of enactment and before October 1, 1989.

(g) Extension of waiver of liability provisions to certain coverage denials for home health services.—Extends waiver of liability for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis or physical, speech, or occupational therapy. A favorable presumption regarding the waiver of liability for

inistratively necessary days.—
s the Secretary to conduct a study to
rment should be made (in a budget-
itals) to a hospital for administrative-
te from the DRG and outliner pay-

essary days defined.—Defines an "ad-
day" as a day of continued inpatient
beneficiary, necessitated by a delay
r the individual in a skilled nursing

ducting study.—Requires the Secre-
udy, to consider the need for such a
disproportionate financial impact of
ospitals (or hospitals in certain loca-
arranging for appropriate post-hos-
ies resulting from a shortage of beds
es where those hospitals are located
from the source of payment for such

in conducting the study, to consider
o minimize the risk of inappropriate
tional or inappropriate institutional
no need post-hospital services in a

in conducting the study, to consider
nisms that can be used to prevent in-
administratively necessary days.
tequires the Secretary to report to
the study no later than January 1,

ility for SNFs, home health agencies,
nues the favorable presumption of
nd home health agencies, and estab-
n for hospices having 2.5 percent or
sis of care not being reasonable and
custodial in nature.
port annually to Congress on (1) the
lenials because care was not reasona-
ustodial; and (2) other information
riateness of denial rates established

s, effective for care furnished on or
month that begins at least 6 months
efore October 1, 1989. For SNFs and
e for services furnished on or after
October 1, 1989.
ability provisions to certain coverage
ces.—Extends waiver of liability for
rage decisions about whether a pa-
r a person needs skilled nursing care
nysical, speech, or occupational ther-
regarding the waiver of liability for

denials on these ground would be available for home health agencies which (1) comply with requirements on timely submittal of bills for payment and medical documentation, (2) promptly notify patients where it is determined that a patient is being or will be furnished items or services which are excluded from coverage, and (3) have no more than 2.5 percent of claims submitted during the previous quarter denied on the basis of home bound or intermittent care requirements.

Effective date.—Effective for services furnished on or after the first day of the first month that begins more than 90 days after date of enactment, with the favorable presumption provisions for denials based on homebound and intermittent coverage decisions effective through September 30, 1089.

(h) Development of uniform needs assessment instrument.—

(1) Development.—Requires the Secretary to develop a uniform need assessment instrument that (A) evaluates the functional capacity of an individual, the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and the social and familial resources available to the individual to meet those requirements; and (B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health related or supportive nature. The Secretary may develop more than one such instrument for use in different situations.

(2) Advisory panel.—Requires the Secretary to develop the instrument in consultation with an advisory panel appointed by the Secretary. The panel is to include experts in the delivery of post-hosptial extended care services, home health services, and long-term care services, and is to include representatives of hospitals, physicians, skilled nursing facilities, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.

(3) Report of instrument.—Requires the Secretary to report to Congress, no later than 1 year after the date of enactment, on the instrument or instruments developed. The report is required to include an evaluation of the advantages to include an evaluation of the advantages and disadvantages of using the instrument or instruments as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries.

Effective date.—Enactment.

(i) Expedited review by fiscal intermediaries.—Requires the Secretary to develop procedures to expedite the determination of whether initial claims submitted for skilled nursing facility, home health services, and hospice care servicies provided (or to be provided) to an individual may be reimbursed by Medicare, in order to minimize the time between when the provider first provides the service to the individual and when the provider first receives notice of an initial determination on whether Medicare will pay for some or all of the provided services.

Effective date.—Requires the Secretary to provide for the expedited procedures no later than one year after the date of enactment.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—

(1) Additional reports.—Extends the requirement for annual reports through 1989.

(2) Information on Quality of post-hospital care.—Requires the annual impact reports to include (A) an evaluation of the adequacy of the procedures for assuring quality of Medicare post-hospital services; (B) and assessment of problems that have prevented groups of Medicare beneficiaries (including those eligible for Medicaid) for receiving appropriate Medicare post-hosptial services; and (C) information on Medicare reconsiderations and appeals for payment for post-hospital services.

Effective date.—Enactment. Applies to reports for years beginning with 1986.

(k) Prior authorization demonstration project.—Requires the Secretary of HHS to conduct a demonstration program concerning prior authoriztaion for Medicare SNF and home health services. Requires the demonstration to include at least four projects implemented not later than July 1, 1987. Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period the Secretary finds necesary to conduct the demonstration.

Requires that the demonstration be developed in consultation with an advisory panel that includes experts in the delivery of SNF services home health services, and long-term care services and include representatives of hospitals, physicians, SNFs, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.

Requires the Secretary to evaluate the demonstration and report to Congress on the evaluation no later than January 1, 1989. Requires the Secretary to address the following issues in the evaluation: (1) the administration in comparison to costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which would not be incurred under prior authorization; (2) impact of prior authorization on access and availability of SNF and home health services in comparison to the current system and on timely discharge of hospital inpatients; and (3) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior authorization versus the current system.

Specifies that funding for the demonstration would come from the Federal Hospital Insurance Trust Fund.

Effective date.—Enactment.

Senate amendment

(a) Refinement of prospective payment system.—No provision.

(b) Requiring notice of hospital discharge rights.—Section 60l(a).—Similar provision.

Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies to admissions to hospitals occurring after such date as the Secre-

Secretary to provide for the expe-
one year after the date of enact-

s on prospective payment system in-
pital care.—
ids the requirement for annual re-

f post-hospital care.—Requires the
e (A) an evaluation of the adequacy
quality of Medicare post-hospital
of problems that have prevented
(including those eligible for Medic-
Medicare post-hosptial services; and
considerations and appeals for pay-

Applies to reports for years begin-

stration project.—Requires the Sec-
demonstration program concerning
re SNF and home health services.
include at least four projects imple-
, 1987. Requires the Secretary to
re requirements to the extent and
ids necessary to conduct the demon-

ation be developed in consultation
ludes experts in the delivery of SNF
and long-term care services and in-
als, physicians, SNFs, home health
ers, fiscal intermediaries, and Medi-

aluate the demonstration and report
no later than January 1, 1989. Re-
s the following issues in the evalua-
comparison to costs under the cur-
view, including costs for uncovered
of liability which would not be in-
on; (2) impact of prior authorization
NF and home health services in com-
and on timely discharge of hospital
d associated coet savings of payment
aim reversals under prior authoriza-

he demonstration would come from
Trust Fund.

payment system.—No provision.
hospital discharge rights.—Section

e Secretary to first prescribe the lan-
after the date of enactment. Applies
urring after such date as the Secre-

tary shall provide, no later than 60 days after the date such language is first prescribed.

(c) Requiring hospitals to provide discharge planning process.—Section 604(b).

(1) Requirement as a condition of participation.—Identical provision.

(2) Discharge planning process defined.—Similar provision.

(3) Effect on accreditation.—Similar provision.

Effective date.—Applies as of one year after the date of enactment.

(d) Review of standards for Medicare conditions of participation for assuming quality of inpatient hospital services.—No provision.

(e) Study of payment for administratively necessary days.—No provision.

(f) Continuing waiver for liability for SNFs, home health agencies, and hospice programs.—No provision.

(g) Extension of waiver of liability provisions to certain coverage denials for home health services.—Section 614.—Extends waiver of liability protection for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis.

Requires the Secretary not later than July 1, 1987, to publish final regulations specifying criteria used as of Jan. 1, 1986, in determining coverage for patients who are homebound or who require skilled nursing care on an intermittent basis.

Effective date.—Effective for coverage denials occurring on or after July 1, 1987.

(h) Development of uniform need assessment instrument.—No provision.

(i) Expedited review of fiscal intermediaries.—No provision.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—No provision.

(k) Prior authorization demonstration project.—Section 604(c).—Requires the Secretary to develop and carry out a demonstration project to determine whether prior and concurrent authorization for SNF and home health services, when used in place of the current waiver of liability policy, will protect beneficiaries against liabilities incurrrd as a result of claim denials. Requires the Secretary to monitor claim denials. Requires the Secretary to monitor the acceptance of beneficiaries by providers to ensure that their placement is not delayed until the results of prior and concurrent review are known. Requires that the demonstration be initiated not later than January 1, 1987, and continue for not more than 2 years.

Authorizes the Secretary to require providers participating in the demonstration to submit such information as the Secretary determines is necessary to evaluate the project. Requires the Secretary to report to Congress on the result of the evaluation not later than April 2, 1988.

Effective date.—Enactment.

Conference agreement

(a) Refinement of prospective payment system.—The conference agreement includes the House provision.

(b) Requiring notice of hospital discharge rights.—The conference agreement includes the House provision.

(c) Requiring hospitals to provide discharge planning process.—The conference agreement includes the House provision with the following clarification. Standards for discharge planning should be applied in a flexible manner in the case of small rural hospitals.

(d) Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.—The conference agreement includes the House provision.

(e) Study of payment for administratively necessary days.—The conference agreement includes the House provision.

(f) Continuing waiver of liability for SNFs, home health agencies, and hospice programs.—The conference agreement includes the House provision with respect to the application of the favorable presumption of liability rules to hospice providers through November 1, 1988. The conference agreement does not include the House provision that would extend the favorable presumption of the waiver of liability for home health agencies and SNFs through FY 1989.

Because many of the denials for payment to home health agencies by fiscal intermediaries stem from the lack of a clear and consistent implementation of the requirements that a patient be "homebound" and in need of "intermitten" skilled care, the conferees urge the Secretary to promulgate clearer definitions of these terms and provide better guidance to agencies and fiscal intermediaries.

(g) Extension of waiver of liability provision to certain coverage denials for home health services.—The conference agreement includes the House provision with amendments. The waiver of liability for "technical" denials would not include denials based on possible need for physical, speech, or occupational therapy. The effective date is delayed to July 1, 1987. The Secretary would be required to report on the frequency of denials for SNF, home health agency, and hospice benefits.

The Secretary would be required to report on the frequency and distribution of payment denials for extended care services, home health services and hospice care in 1987 and 1988.

(h) Development of uniform needs assessment instrument.—The conference agreement includes the House provision. The conferees note that an evaluation of the functional status of an individual should include not only a description of the individual's diagnosis, but an evaluation of the constraints on the individual's ability to engage in activities of daily living.

(i) Expedited review by fiscal intermediaries.—The conference agreement does not include the House provision.

(j) Including in annual reports on prospective payment system information on quality of post-hospital care.—The conference agreement includes the House provision.

(k) Prior authorization demonstration project.—The conference agreement includes the House provision with technical amendments. The agreement further changes the date for implementation of the demonstration from July 1, 1987 to January 1, 1987 and delays the date for submission of a report to Congress from January 1, 1989 to February 1, 1989.

il discharge rights.—The conference
provision.
ovide discharge planning process.—
udes the House provision with the
is for discharge planning should be
n the case of small rural hospitals.
nedicare conditions of participation
t hospital services.—The conference
provision.
ministratively necessary days.—The
he House provision.
ity for SNFs, home health agencies,
onference agreement includes the
o the application of the favorable
hospice providers through Novem-
eement does not include the House
the favorable presumption of the
lth agencies and SNFs through FY

for payment to home health agen-
m from the lack of a clear and con-
requirements that a patient be
ntermitten" skilled care, the confer-
nulgate clearer definitions of these
nce to agencies and fiscal interme-

bility provision to certain coverage
es.—The conference agreement in-
amendments. The waiver of liabil-
not include denials based on possi-
occupational therapy. The effective
The Secretary would be required to
ials for SNF, home health agency,

red to report on the frequency and
for extended care services, home
in 1987 and 1988.
eeds assessment instrument.—The
he House provision. The conferees
functional status of an individual
ption of the individual's diagnosis,
aints on the individual's ability to
g.
l intermediaries.—The conference
House provision.
on prospective payment system in-
pital care.—The conference agree-
on.
nstration project.—The conference
provision with technical amend-
changes the date for implementa-
July 1, 1987 to January 1, 1987 and
f a report to Congress from Janu-

6. OFF-BUDGET TREATMENT OF FEDERAL HOSPITAL INSURANCE TRUST FUND IN FISCAL YEAR 1987 (SECTION 10206 OF HOUSE BILL)

Present law

Federal Hospital Insurance (HI) Trust Fund receipts and disbursements are included in the unified budget of the U.S. Government, but are scheduled to be removed from the unified budget in FY 1993.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) removed the receipts and disbursements of the Social Security Trust Funds (the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, known as OASDI) from the unified budget effective for FY 1986. The disbursements and expenditures of the Social Security Trust Funds, however, are included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation.

House bill

Removes the receipts and disbursements of the Federal Hospital Insurance (HI) Trust Fund, from the unified budget of the U.S. Government. As under OASDI, the disbursements and expenditures of the HI trust fund would be included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation and would be exempt from any general budget limitation on outlays imposed by statute.

Effective date.—Applies to fiscal years beginning after September 30, 1986, and end before October 1, 1992.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART A (SECTION 10207 OF HOUSE BILL)

Present law

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—See item (section 4524 of House bill) for this description.

(b) Extended designation period for regional referral centers.—See item 2 (section 10202 of House bill; section 601 of Senate amendment) for this description.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—Medicare-certified hospices are required to maintain no more than 20 percent of total days as inpatient days. Connecticut Hospice, Inc., currently has waivers for a number of Medicare requirements. These waivers will no longer be in effect on October 1, 1986.

(d) Massachusetts Medicare repayment.—Massachusetts operated a Statewide hospital demonstration project from October 1, 1982,

through June 30, 1985. The Secretary is required to judge the effectiveness of the demonstration to ensure that Medicare expenditures under the demonstration are not greater than they would have been under Medicare regular reimbursement rules. The Secretary has determined that Medicare part A overpayments were made during the first two years of the Massachusetts waiver and has established a repayment schedule for the alleged overpayments.

(3) Part A COBRA technical and other miscellaneous corrections.—Current law contains a number of technical errors.

House bill

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—See item 18 (section 4524 of House bill) for this description.

(b) Extended designation period for regional referral centers.—See item 2(h) (Section 10202 of House bill; section 601 of Senate amendment) for this description.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—Waives Connecticut Hospice, Inc., from the 80/20 inpatient/home care day requirement for two years, provided they do not exceed 50 percent of total days as inpatient days.

(d) Massachusetts Medicare repayment.—Prohibits the Secretary from recouping or otherwise reducing payments to Massachusetts hospitals on or after the date of enactment of this section and before January 1, 1988.

(e) Part A COBRA technical and other miscellaneous corrections.—Corrects technical errors as follows: (1) corrects and clarifies a section regarding payments under the disproportionate share provision; (2) corrects and clarifies a section regarding payments under the indirect teaching adjustment; (3) clarifies that all hospitals which have a Medicare provider agreement would have to abide by the emergency care requirements; (4) allows SNFs to make election to be paid on a prospective payment basis based on their cost reporting periods rather than on a Federal fiscal year basis; (5) clarifies that the Hospital Insurance tax on State and local government does not apply to certain election workers (Note: see Revenue Provisions, item 1 (section 661 of Senate amendment) for a description of a similar provision.); and (6) makes other miscellaneous corrections to COBRA and related laws.

Effective date.—Enactment, except the technical corrections are effective as if they had been included in the enactment of the laws they amend.

Senate amendment

(a) One-year extension of pass-through for costs of certified registered nurse anesthetists.—No provision.

(b) Extended designation period for regional referral centers.—See item 2 (Section 10202 of House bill; Section 601 of Senate amendment) for this description.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.—No provision.

(d) Massachusetts Medicare repayment.—No provision.

(e) Part A COBRA technical and other miscellaneous corrections.—No provision. Note: See Revenue provisions, item 1 (Section

Senate amendment

Allows the Secretary to establish a separate threshold percentage of low-income patients required for rural hospitals with 300 or more beds to qualify for Medicare disproportionate share payments. These hospitals would have the Federal portion of the PPS payment increased by the same formula currently used for urban hospitals with 100 or more beds (2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent).

Rural hospitals with less than 300 beds would continue to be required to have a percentage of low-income patients of at least 45 percent in order to qualify for Medicare disproportionate share payments. These hospitals would continue to have their payment increased by 4 percent.

Effective date.—Applies to discharges occurring on or after October 1, 1986.

Conference agreement

The conference agreement includes the Senate amendment with an amendment to change the bed threshold to 500. In addition, the present law provision which allows payments to disproportionate share hospitals will be continued for one additional year in a budget neutral fashion.

II. Medicare Provisions (Parts A and B)

9. Elimination of periodic interim payments (PIP) for prospective payment system (PPS) hospitals and prompt payment for medicare providers (section 10221 of house bill; section 612 of senate amendment)

Present law

Current law does not specifically provide for periodic interim payments (PIP); however, regulations allow hospitals, skilled nursing facilities, and home health agencies which meet certain requirements to receive Medicare periodic interim payments (PIP) every 2 weeks, based on estimated annual costs without regard to the submission of individual bills. At the end of the year, a settlement is made. In final regulations published on August 15, 1986, the Department of Health and Human Services eliminated PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987.

The Health Care Financing Administration recently issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. "Clean" Medicare claims are those not requiring development for payment safeguard activities or additional information. The guidelines apply to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers.

House bill

(a) Elimination of PIP for PPS hospitals.—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals) except for disproportionate share hospitals, sole community hospitals, and

stablish a separate threshold percentage
quired for rural hospitals with 300 or
Medicare disproportionate share pay-
ld have the Federal portion of the PPS
same formula currently used for urban
beds (2.5 percent plus half the differ-
and the hospital's percentage of low-
ed 15 percent).
than 300 beds would continue to be re-
e of low-income patients of at least 45
y for Medicare disproportionate share
would continue to have their payment

to discharges occurring on or after

t includes the Senate amendment with
e bed threshold to 500. In addition, the
h allows payments to disproportionate
ntinued for one additional year in a

ROVISIONS (PARTS A AND B)

INTERIM PAYMENTS (PIP) FOR PROSPEC-
S) HOSPITALS AND PROMPT PAYMENT FOR
TION 10221 OF HOUSE BILL; SECTION 612

ecifically provide for periodic interim
gulations allow hospitals, skilled nurs-
alth agencies which meet certain re-
icare periodic interim payments (PIP)
imated annual costs without regard to
l bills. At the end of the year, a settle-
ulations published on August 15, 1986,
nd Human Services eliminated PIP for
ospitals, effective July 1, 1987.
ncing Administration recently issued
art A intermediary and part B carrier
t of "clean" Medicare claims within 27
edicare claims are those not requiring
afeguard activities or additional infor-
ply to Medicare claims submitted by
oviders, and suppliers.

PPS hospitals.—Eliminates periodic in-
nt services in PPS hospitals (including
ilitation units of PPS hospitals) except
ospitals, sole community hospitals, and

hospitals receiving Medicare payment under a State hospital reimbursement system if payment on a PIP basis is an integral part of the reimbursement system.

Eligible PPS-exempt hospitals and other costbased providers (i.e., outpatient hospitals skilled nursing facilities, and home health agencies) may continue to receive periodic interim payments.

If a PPS hospital has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary is required to make available accelerated payments.

(b) Part A prompt payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part A intermediary by the 22nd calendar day after the day on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Intermediaries are required to notify the beneficiary or provider who submits a claim, within 22 calendar days after the date on which a claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the day the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.

(c) Part B prompt payment.—Provides (for Medicare claims not paid on the PIP basis) that if payment is not made by a part B carrier by the 22nd calendar day (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Part B carriers are required to notify the beneficiary, physician, or supplier who submits a claim, within 22 calendar days (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a claim is received of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the date the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.

(d) Interest Rate.—Interest under this provision is paid at the rate used for purposes of section 3902(a) (Interest Penalties) of title 31 (Money and Finance), United States Code.

(e) Federal administrative costs.—Carriers and intermediaries will be reimbursed for interest payments from amounts made available for Federal administrative costs to carry out this provision (other than the amounts made available for intermediary and carrier agreements).

(f) Definition of "clean" claim.—A "clean" claim is defined as a claim that has no defect or impropriety (including missing required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.

(g) Timely amendments to agreements and regulations.—No provision.

Effective date.—Applies PIP provision for discharges occurring on or after August 1, 1987. The timely payment for part A claims provision applies to claims received on or after October 1, 1987. The prompt payment for Medicare physicians and suppliers provision applies to claims received on or after October 1, 1987.

Senate amendment

(a) Elimination of PIP for PPS hospitals.—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals).

The elimination of PIP for PPS hospitals would be delayed until the intermediary demonstrates that it has complied with the prompt payment requirement for at least three consecutive months. If the intermediary fails to meet the prompt payment requirements for three consecutive months, all the PPS hospitals it serves may choose to be placed on PIP.

Eligible PPS-exempt hospitals and other cost-based providers (i.e., skilled nursing facilities and home health agencies) may continue to receive periodic interim payments.

(b) Part A prompt payment.—Requires (for Medicare claims not paid on a PIP basis) payment to be made by a part A intermediary for at least 95 percent of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received. In FY 1987, the applicable number of calendar days is 27, FY 1988 it is 26, in FY 1989 it is 25, and in FY 1990 and thereafter, it is 24.

For clean claims not paid on a PIP basis, if payment is not made by the applicable number of days after the date on which a clean claim is received, interest would be paid beginning on the day after the date on which payment was due, and ending on the date payment is made.

(c) Part B prompt payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part B carrier for at least 95 percent of all Medicare clean claims by the applicble number of calendar days after the day on which a clean claim is received, interest would be paid beginning on the day after the day on which payment was due and ending on the day payment is made.

(d) Interest rate.—Similar provision.

(e) Federal administrative costs.—No provision.

(f) Definition of "clean" claim.—A "clean" claim is defined as a claim which meets Medicare requirements for payment under part A or part B respectively. In addition, in order for a part A claim to be a clean claim it must meet the requirements of section 1814(a)(1) (which defines a Medicare claim).

(g) Timely amendments to agreements and regulations.—Requires the Secretary to provide for timely amendments to intermediary and carrier agreements and regulations to the extent necessary to implement these provisions.

Effective date.—Applies to claims received on or after October 1, 1986, except that the interest penalties apply to claims received on or after April 1, 1987.

PIP provision for discharges occurring
. The timely payment for part A claims
received on or after October 1, 1987. The
icare physicians and suppliers provision
on or after October 1, 1987.

or PPS hospitals.—Eliminates periodic in-
ient services in PPS hospitals (including
abilitation units of PPS hospitals).
for PPS hospitals would be delayed until
strates that it has complied with the
ement for at least three consecutive
ry fails to meet the prompt payment re-
ecutive months, all the PPS hospitals it
aced on PIP.
ospitals and other cost-based providers
ties and home health agencies) may con-
nterim payments.
ient.—Requires (for Medicare claims not
ent to be made by a part A intermediary
all Medicare clean claims by the applica-
ays after the day on which a clean claim
ne applicable number of calendar days is
' 1989 it is 25, and in FY 1990 and there-

id on a PIP basis, if payment is not made
of days after the date on which a clean
would be paid beginning on the day after
nt was due, and ending on the date pay-

ient.—Provides (for Medicare claims not
if payment is not made by a part B carri-
of all Medicare clean claims by the applic-
ays after the day on which a clean claim
d be paid beginning on the day after the
as due and ending on the day payment is

ar provision.
ve costs.—No provision.
' claim.—A "clean" claim is defined as a
are requirements for payment under part
In addition, in order for a part A claim to
neet the requirements of section 1814(a)(1)
· claim).
to agreements and regulations.—Requires
for timely amendments to intermediary
nd regulations to the extent necessary to
ns.
s to claims received on or after October 1,
rest penalties apply to claims received on

Conference agreement

(a) Elimination of PIP for PPS hospitals.—The conference agreement includes the Senate amendment with a modification. Under the agreement, the elimination of periodic interim payment (PIP) would not apply to prospective payment system hospitals (and their distinct psychiatric or rehabilitation units) with a disporportionate share adjustment percentage of at least 5.1 percent. For purposes of this provision, the disproportinate share adjustment shall be based upon the data base used for establishing the standardized amounts for fiscal year 1987 (i.e., the disproportionate share percentage calculated from the hospital's percentage of low income patients, which were based on the SSI percentage from 1985 SSI data and the medicaid percentage from 1984 cost report data). Prospective payment system hospitals with 100 or fewer beds located in rural areas could also qualify for continued periodic interim payments.

On a one-time basis during the cost reporting period beginning in fiscal year 1987, qualified disproportionate share and qualified rural hospitals could elect to continue receiving periodic interim payments provided that they were receiving such payments on June 30, 1987 and provided that they continue to meet the requirements specified in regulations that were applicable on October 1, 1986. Qualification for periodic interim payments for eligible disproportionate share hospials and eligible rural hospitals with 100 beds or less would be limited to those hositals which qualify under this exception during the cost reporting period beginning in fiscal year 1987. These qualified hospitals could continue to receive PIP payments indefinitely provided that they continue to meet standards established by the Secretary that were applicable on October 1, 1986. The conferees expect the Health Care Financing Administration to identify hospitals which would qualify for continued PIP payments and to inform such hospitals of their one-time opportunity to continue PIP payments.

The conferees recognize that elimination of PIP may present serious financial difficulties for certain hospitals. In addition to the current criteria under which accelerated payments are generally available, accelerated payments to hospitals should be made available by the Secretary if the hospital can demonstrate that it is experiencing significant cash flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

The PIP option would be retained for PPS-exempt hospitals, skilled nursing facilities, home health agencies, and hospitals in states holding waivers under section 1886(c) or section 1814(b)(3); and would be made available to hospice providers. The conferees require that the payment mechanism and requirements be comparable to those which are currently in place under 42 CFR 405.454(j).

(b) Part A prompt payment.—The conference agreement includes the Senate amendment with a modification which specifies that 95 percent of "clean" claims shall be paid in not more than 30 calendar days in FY 1987; 26 for FY 1988; 25 for FY 89 and 24 for FY 1990 and for each of the subsequent years.

Periodic interim payments could not be eliminated for hospitals receiving such payments until the intermediary has met the prompt payment standards for three consecutive months. Periodic interim payments could be provided for those hospitals that meet the standards required by the Secretary, as in place as of October 1, 1987, if an intermediary fails to meet the applicable prompt payment standard for three consecutive months. For providers not receiving periodic interim payments interest would be required to be paid on claims not processed within the specified time periods.

(c) Part B prompt payment.—The conference agreement includes the Senate amendment with a modification which specifies that 95 percent of "clean" claims shall be paid in not more than 30 calendar days in FY 1987; 26 for FY 1988; 25 for FY 1989; and 24 for FY 1990 and for each of the subsequent years except that for participating physicians the standard shall be 19 days for FY 1988; 18 for FY 1989 and 17 for FY 1990 and for each subsequent years. For claims not paid within the specified time period interest would accrue.

The conferees are concerned about the rapid slow down in payments to beneficiaries and providers that has developed over the last year. The conferees hope that intermediaries and carriers process claims in the most expeditious manner and consider the limits established in this bill as an absolute ceiling with a goal of processing claims according to historical experience. The conferees urge the Administration to manage more appropriately the payment function carried out by medicare's intermediaries and carriers and that the Administration request funds necessary to improve the administration of the medicare program and to pay claims in a timely manner consistent with the historical levels.

The Secretary should establish standards for timely payment of claims that do not meet the definition of "clean" claims or fail to meet the 95 percent minimum requirement. The conferees do not expect that the exclusion of some claims from timeliness requirements in this bill will result in increased numbers of claims classified as incomplete.

(d) Interest rate.—The conference agreement includes the House provision.

(e) Federal administrative costs.—The conference agreement includes the House provision.

(f) Definition of clean claims.—The conference agreement includes the Senate amendment with an amendment clarifying the definition of a clean claim. A "clean" claim is defined as a claim that has no defect or impropriety (including the absence of required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.

(g) Timely amendments to agreements and regulations.—The conference agreement includes the Senate amendment.

10. HEALTH MAINTENANCE ORGANIZATION AMENDMENTS (SECTIONS 10222 AND 4510 OF HOUSE BILL)

Present law

Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for

ould not be eliminated for hospitals
il the intermediary has met the
three consecutive months. Periodic
ovided for those hospitals that meet
Secretary, as in place as of October
s to meet the applicable prompt pay-
cutive months. For providers not re-
nts interest would be required to be
thin the specified time periods.
-The conference agreement includes
modification which specifies that 95
be paid in not more than 30 calen-
1988; 25 for FY 1989; and 24 for FY
quent years except that for partici-
shall be 19 days for FY 1988; 18 for
and for each subsequent years. For
pecified time period interest would

about the rapid slow down in pay-
oviders that has developed over the
hat intermediaries and carriers proc-
ous manner and consider the limits
solute ceiling with a goal of process-
ical experience. The conferees urge
e more appropriately the payment
re's intermediaries and carriers and
t funds necessary to improve the ad-
program and to pay claims in a
the historical levels.
sh standards for timely payment of
finition of "clean" claims or fail to
requirement. The conferees do not
me claims from timeliness require-
increased numbers of claims classi-

ence agreement includes the House

sts.—The conference agreement in-

s.—The conference agreement in-
with an amendment clarifying the
"clean" claim is defined as a claim
riety (including the absence of re-
tation) or particular circumstances
t prevents timely payment.
eements and regulations.—The con-
Senate amendment.

ANIZATION AMENDMENTS (SECTIONS
10 OF HOUSE BILL)

curity Act, as amended by the Tax
y Act of 1982 (TEFRA), provides for

Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

(a) Two for one rule.—Section 114(c)(2) of TEFRA provides the HMOs with enrolled individuals under an existing cost-contract and convert such individuals to enrollment under a risk contract. However, the plan must enroll two new Medicare enrollees under the risk contract for each enrollee converted from the cost to the risk contract. This provision is known as the "two for one" rule.

(b) Explanation of enrollee rights.—Each HMO and CMP must meet certain requirements to be eligible to contract with the Secretary to enroll Medicare members. These requirements include accepting financial responsibility for contracted services and providing for meaningful grievance procedures. The enrolling member of a risk contracting plan accepts that, except for emergency and out-of-area care, neither the plan nor Medicare has financial responsibility for services not rendered by or through the contracting plan.

(c) Restriction on waivers of 50 percent Medicare and Medicaid enrollment.—Each Medicare contracting HMO and CMP must have at least half of their membership composed of enrollees that are not entitled to benefits under either Medicare or Medicaid. The Secretary can waive this requirement only if circumstances warrant such waiver and the organization is making reasonable efforts to enroll individuals not entitled to Medicare or Medicaid.

(d) Prompt payment of claims.—Each HMO and CMP is financially responsible for the cost of benefits used by its enrollees, whether provided directly or under arrangement.

(e) Financial disclosure.—Each HMO and CMP is required to comply with Section 1318 of the Public Health Service Act (relating to financial disclosure).

(f) Civil monetary penalties.—Medicare contracts with HMOs and CMOs are automatically annually renewable, unless the Secretary determines that the organization has failed to meet its contractual obligations. The Secretary may terminate such contracts at any time if it is found (after appropriate notice and opportunity for hearing) that the organization has substantially failed to carry out the terms of the contractual requirements.

(g) Study of AAPCC and ACR.—Reimbursement of risk contracting HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

(h) Allowing Medicare beneficiaries to disenroll at a local Social Security office.—No provision.

House bill

(a) Two for One rule.—

Section 10222.—Amends TEFRA such that the "two for one rule" does not apply for current nonrisk HMO Medicare enrollees for months beginning with April 1987.

Section 4510.—No provision.

(b) Explanation of enrollee rights.—

Section 10222.—Requires HMOs and CMPs contracting on either a risk or cost basis to provide each enrollee at the time of enrollment, and not less than annually thereafter, an explanation of the enrollee's rights, including enrollee's rights to benefits from the organization, restrictions on Medicare payments for services provided other than by or through the organization, out-of-area coverage, coverage of emergency services, and appeal rights of enrollees.

Section 4510.—No provision.

(c) Restriction on waivers of 50 percent Medicare and Medicaid enrollment.—

Section 10222.—

(1) Limits the Secretary's authority to issue new waivers of the 50 percent rule to plans with service areas that include populations more than half of which are entitled to either Medicare or Medicaid.

(2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend enrollment of Medicare enrollees by the organization.

(3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given the authority to suspend enrollments under Medicare if the organization does not meet scheduled enrollment goals approved by the Secretary.

Section 4510.—

(1) Similar provision.

(2) Provides that, if an eligible organization fa comply with the requirements for a waiver, the Sec may provide for a suspension of Medicare payment organization.

(3) Provides that, in the case of organizations rently have a waiver but that do not meet th ments for such waiver as amended by this sectio retary is given the authority to suspend paym Medicare.

(d) Prompt payments of claims.—

Section 10222.—Requires that risk contracting must provide for payment of claims submitted fo ices and supplies furnished to their enrollees providers and suppliers not having a contract with the organization within the same time l payment that apply to Medicare carriers ar diaries. If, after notice and opportunity for nization fails to make prompt payments, provide for direct payment of amount ow the amount of such payments (and amo Secretary in making such payments) from pa made to such organizations.

Section 4510.—No provision.

(e) Financial disclosure.—

Section 10222.—Requires that HMOs and CMPs supply, on request of the Secretary and according to regulations specified

HMOs and CMPs contracting on
o provide each enrollee at the time
than annually thereafter, an expla-
ghts, including enrollee's rights to
ion, restrictions on Medicare pay-
other than by or through the orga-
ge, coverage of emergency services,
es.
on.
50 percent Medicare and Medicaid

ry's authority to issue new waivers
o plans with service areas that in-
than half of which are entitled to
icaid.
an eligible organization fails to
ements for a waiver, the Secretary
nt of Medicare enrollees by the or-

the case of organizations that cur-
but that do not meet the require-
as amended by this section, the Sec-
ority to suspend enrollments under
zation does not meet scheduled en-
l by the Secretary.

an eligible organization fails to
ements for a waiver, the Secretary
ension of Medicare payments to the

the case of organizations that cur-
but that do not meet the require-
as amended by this section, the Sec-
thority to suspend payments under

s.—
that risk contracting organizations
of claims submitted for covered serv-
d to their enrollees by physicians,
having a contractual arrangement
in the same time limits for prompt
edicare carriers and fiscal interme-
opportunity for a hearing, an orga-
mpt payments, the Secretary may
t of amount owed and then deduct
ents (and amounts incurred by the
payments) from payment otherwise

on.

that HMOs and CMPs supply, on
ıd according to regulations specified

by the Secretary, information as to ownership of subcontractors with whom the organization had business transactions in excess of $25,000 during the preceding 12 months, and complete information regarding significant business transactions between organizations and wholely owned subcontractors or suppliers during the 5-year period preceding the date of such request. The organization is required to notify the Secretary of loans or other special financial arrangements between the organization and its subcontractors, affiliates, and related parties.

Section 4510.—No provision.

(f) Civil money penalties.—

Section 10222.—Provides that any risk-contracting organization that fails substantially to provide any medically necessary items and services that are required to be provided under such contract, is subject to a civil money penalty of not more than $2,000 for each such failure if the failure has adversely affected (or has the likelihood of adversely affecting) individuals enrolled under such contract. Such penalties are subject to the requirements generally applicable to civil money penalties under Section 1128A of the Social Security Act (except for subsection (a)).

Section 4510.—No provision.

(g) Study of AAPCC and ACR.—

Section 10222.—Requires the Secretary to provide, through a contract with an appropriate organization, for a study of the methods by which the AAPCC and the ACR can be refined to more accurately reflect the cost of providing care to different classes of patients, and to submit to Congress not later than January 1, 1988 specific legislative recommendations concerning the methods by which these measures can be refined.

(h) Allowing Medicare Beneficiaries to Disenroll at a Local Social Security Office.—

Section 10222.—Requires the Secretary to provide that beneficiaries may disenroll from HMOs and CMPs at any local office of the Social Security Administration on or after June 1, 1987.

Section 4510.—No provision.

Effective date.—Section 10222.—Enactment except for the following:

(b) January 1, 1987.

(c) Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment.

(d) Applies to services furnished on or after July 1, 1987.

(e) Applies to contracts as of January 1, 1987.

Section 4510.—Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment.

Senate amendment

No provision.

Conference agreement

(a) Two for One rule.—The conference agreement includes section 10222 of the House provision.

(b) Explanation of enrollee rights.—The conference agreement includes section 10222 of the House provision. All HMO/CMP's would be required to provide medicare beneficiaries an explanation of their rights as HMO enrollees, including but not limited to understandable descriptions of the benefits package, the meaning of any "lock-in" provisions, the scope of out-of-area coverage and emergency and urgently needed services and appeal rights. This information would be supplied to beneficiaries enrolled in risk contract HMO/CMP's effective January 1, 1987 and no less often than every January thereafter.

Restriction of waivers of 50 percent Medicare and Medicaid enrollment.—The conference agreement includes section 10222 of the House provision with two amendments:

(1) Restrictions on new waivers—New waivers may only be granted "to the extent that" more than 50 percent of the population area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.

New waivers of the requirements of section 1876(f)(1) of the Act would be allowed, at the discretion of the Secretary, for a period not to exceed three years if the organization is publicly owned and operated. The conferees note that the original purpose of this requirement was to ensure that the organization remain financially sound, and that it be of sufficient quality to attract nonmedicare enrollees. Because the financial viability of a publicly owned HMO would be guaranteed by the government, but such an HMO would typically serve a disproportionate share of medicaid and medicare beneficiaries, the requirements of section 1876(f)(1) do not serve their purpose and can appropriately be waived.

(2) Sanctions for noncompliance—If an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend medicare payments to the organization for beneficiaries newly enrolled after the date of a finding of noncompliance, and may also suspend new renrollment of medicare beneficiaries by the organization.

In the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary would be given the authority to suspend medicare payments for beneficiaries newly enrolled after the date of a finding of noncompliance, and to suspend new enrollments if the organization does not meet scheduled enrollment goals approved by the Secretary.

No new waivers of the current rule requiring that no more than 50 percent of enrollees be medicare or medicaid eligible would be granted other than for exceptions specified in the bill. Where an existing waiver has been granted for reasons other than "disproportionate" representation, the Secretary must establish a schedule under which each waived organization can meet the 50/50 requirement. Where a waiver has been granted for other than "disproportionate" representation, the waivers may only be extended if the Secretary determines that the organization (or its successor) has made and is continuing to make reasonable efforts to meet scheduled enrollment goals

e rights.—The conference agreement in-House provision. All HMO/CMP's would edicare beneficiaries an explanation of ees, including but not limited to undere benefits package, the meaning of any pe of out-of-area coverage and emergenrvices and appeal rights. This informa- beneficiaries enrolled in risk contract ary 1, 1987 and no less often than every

*50 percent Medicare and Medicaid en-*agreement includes section 10222 of the mendments:

ew waivers—New waivers may only be that" more than 50 percent of the poputhe organization consists of individuals nefits under this title or under a State tle XIX.

requirements of section 1876(f)(1) of the at the discretion of the Secretary, for a ree years if the organization is publicly The conferees note that the original purnt was to ensure that the organization nd, and that it be of sufficient quality to nrollees. Because the financial viability MO would be guaranteed by the governO would typically serve a disproportionand medicare beneficiaries, the require-(f)(1) do not serve their purpose and can d.

ncompliance—If an eligible organization he requirements for a waiver, the Secredicare payments to the organization for rolled after the date of a finding of non- also suspend new renrollment of medihe organization.

izations that currently have a waiver but equirements for such waiver as amended ecretary would be given the authority to yments for beneficiaries newly enrolled nding of noncompliance, and to suspend he organization does not meet scheduled oved by the Secretary.

the current rule requiring that no more rollees be medicare or medicaid eligible her than for exceptions specified in the ng waiver has been granted for reasons rtionate" representation, the Secretary dule under which each waived organiza-0 requirement. Where a waiver has been n "disproportionate" representation, the xtended if the Secretary determines that s successor) has made and is continuing fforts to meet scheduled enrollment goals

approved by the Secretary. The Secretary would be given authority to suspend further medicare enrollment if the waivered HMO/CMP fails to meet its enrollment schedule (in order to come into compliance with the 50/50 rule). If the HMO/CMP does not have a 50/50 waiver, but is out of compliance with the 50/50 rule, the Secretary would be given authority to freeze new medicare enrollment and to suspend medicare payments for new enrollments after the finding of non-compliance.

The conference agreement clarifies that the Secretary has the authority, to terminate (after reasonable notice and opportunity for hearing) contracts entered into under section 1876 if the organization substantially fails to meet the requirements of the new section 1876(f) relating to the 50/50 membership requirements.

(d) Prompt payment of claims.—The Conference agreement includes section 10222 of the House provision with an amendment that the requirements of the provision become effective with respect to services furnished on or after January 1, 1987. Effective beginning on January 1, 1987 until December 31, 1987, "clean" claims submitted for services and supplies furnished to HMO/CMP enrollees pursuant to a Section 1876 contract furnished by physicians, providers and suppliers not having a contractual arrangement with the organization must be paid within thirty calendar days of receipt by the HMO/CMP. The conferees encourage HMO/CMP's to pay such claims in a shorter period than the maximum of 30 calendar days as required in this bill, especially in light of the fact that HMO/CMP's are paid prospectively by the medicare program. For calendar year 1988 the prompt payment standard would be 26 days; for 1989, 25 days; and for 1990 and beyond, 24 days. If the standards are not met, the Secretary would have the authority to provide for direct payment of the amounts owed to such providers and suppliers. In this case, the Secretary would provide for an appropriate reduction in the amount of payments otherwise made to the organization to reflect such payments.

(e) Financial disclosure.—The conference agreement includes section 10222 of the House provision.

(f) Civil monetary penalties.—The conference agreement includes section 10222 of the House provision with an amendment that the amount of the penalty is equal to $10,000 for each substantial failure to provide medically necessary items or services that are required to be provided under the contract. In determining whether the requirements of this section were breached, the Secretary is expected to take into consideration generally accepted HMO practice patterns for the delivery of medically necessary care.

(g) Study of the AAPCC and ACR.—The conference agreement includes section 10222 of the House provision.

(h) Allowing Medicare beneficiaries to disenroll at a local Social Security office.—The conference agreement includes section 10222 of the House provision.

(i) Use of benefit stabilization funds during the 1986 contract year.—The conference agreement allows amounts withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund under section 1876(g)(5) during the 1986 contract period to be withdrawn by

the organization to the extent that the organization was paid less than it would have otherwise been paid under a risk contract with the Secretary as a result of Federal spending reductions triggered under the Balanced Budget and Emergency Deficit Control Act of 1985.

11. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE (SECTION 10223 OF HOUSE BILL; SECTIONS 614 AND 615 OF SENATE AMENDMENT)

Prsent law

(a) Provider representation of beneficiaries on appleals and appeal of technical denials.—If a beneficiary disagrees with a payment denial for services provided under Medicare Part A, he or she is entitled to appeal the determination. In the past, beneficiaries have been permitted to be represented in their appeals by the provider who furnished the services in question. However, in April 1984, HCFA issued an intermediary manual instruciton prohibiting such representation. HCFA also has prohibited appeals of "technical" denials, such as homebound and intermittent care requirements for home health services.

(b) Prohibition of certain physician incentive plans.—Section 1866(d) of the Social Security Act provides for Medicare payments to most hospitals on a prospective basis. These PPS hospitals are responsible for the costs of all medically necessary part A inpatient services provided to Medicare beneficiaries during their inpatient stay. Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

(c) Study to develop a strategy for quality review and assurance.—No provision.

House bill

(a) Provider representation of beneficiaries on appeals and appeal of technical denials.—Allows providers to represent beneficiaries on appeals, but prohibits representation by a provider with respect to issues described in section 1879(aX2) of the Social Security Act unless the provider has waived any rights for payment from the beneficiary for services involved in the appeal.

Provides beneficiaries the right to appeal any payment denial for benefits under part A or part B home health services.

Effective date.—Enactment.

(b) Prohibition of certain physician incentive plans.—

(1) Prohibition of incentive payments.—Prohibits a hospital or risk-contracting HMO or CMP from knowingly making incentive payments to a physician as an inducement to reduce or limit services provided to Medicare beneficiaries who are under the direct care of the physician. With respect to HMOs and CMPs, the prohibition applies to Medicare enrollees of

extent that the organization was paid less
rwise been paid under a risk contract with
t of Federal spending reductions triggered
lget and Emergency Deficit Control Act of

TO IMPROVEMENT OF QUALITY OF CARE (SEC-
: BILL; SECTIONS 614 AND 615 OF SENATE

tion of beneficiaries on appleals and appeal
f a beneficiary disagrees with a payment
ided under Medicare Part A, he or she is
termination. In the past, beneficiaries have
presented in their appeals by the provider
ices in question. However, in April 1984,
ediary manual instruciton prohibiting such
also has prohibited appeals of "technical"
und and intermittent care requirements for

rtain physician incentive plans.—Section
curity Act provides for Medicare payments
prospective basis. These PPS hospitals are
of all medically necessary part A inpatient
dicare beneficiaries during their inpatient
ie Social Security Act, as amended by the
esponsibility Act of 1982 (TEFRA), provides
s to Health Maintenance Organizations
e Medical Plans (CMPs) on either a risk or
. In general, risk contracting plans are fi-
or the cost of all benefits their enrollees
gible for under Medicare while enrolled in

strategy for quality review and assurance.—

ation of beneficiaries on appeals and appeal
Allows providers to represent beneficiaries
ts representation by a provider with respect
ection 1879(a)(2) of the Social Security Act
s waived any rights for payment from the
involved in the appeal.
s the right to appeal any payment denial for
r part B home health services.
tment.
ain physician incentive plans.—
f incentive payments.—Prohibits a hospital
HMO or CMP from knowingly making in-
o a physician as an inducement to reduce or
vided to Medicare beneficiaries who are
are of the physician. With respect to HMOs
ohibition applies to Medicare enrollees of

such entities. Hospitals and risk-contracting HMOs and CMPs who knowingly make such payments are subject to civil money penalties of $2,000 for each such individual with respect to whom the payments are made, in addition to any other penalties that may be prescribed by law. Any physician who knowingly accepts such incentive payments is subject to a civil money penalty of $2,000 for each such individual with respect to whom such payments are made, in addition to any other panalties prescribed by law.

(2) Study of incentive arrangements.—Requires the Secretary to conduct a study of inicentive arrangements offered to physicians by HMOs and CMPs, and to report the findings to Congress no later than April 1, 1987. The report shall include recommendations for providing exceptions for such organizations from the prohibition specified under (1) for incentive payments that encourage efficiency in the utilization of services but do not have a substantial potential for an adverse effect on quality.

Effective date.—The prohibition and civil money penalty provisions apply to payments made by hospitals occurring more than 6 months after enactment, and to payments made by risk contracting plans on or after January 1, 1988.

(c) Study to develop a strategy for quality review and assurance.—

(1) In general.—Requires the Secretary to arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under medicare.

(2) Items included in the study.—The study is required among other items, to (a) identify the appropriate considerations which should be used in defining "quality of care"; (b) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care; (c) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done; (d) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care; (e) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress; (f) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care; (g) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and (h) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) Report.—Requires the Secretary to report to Congress, no later than 2 years after the date of enactment. The report shall address the items in (2) above and shall include recommendations with respect to strengthening quality assurance and review activities for Medicare services.

(4) Arrangement for study.—Requires the Secretary to request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary is required to enter into an ap-

propriate arrangement with the Academy for conducting the study. If the Academy does not submit an acceptable application, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an arrangement for the study with the entity which submits the best application.

Requires the Secretary, in developing plans for the conduct of the study, to assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring and quality of care are consulted.

Effective date.—Enactment.

Senate amendment

(a) Provider representation of beneficiaries on appeals and appeal of technical denials.—Similar provision, except prohibits provider representing beneficiary from imposing any financial liability on the beneficiary in connection with representation. Also prohibits costs incurred by provider for representing a beneficiary in an unsuccessful appeal from being allowed as reasonable costs.

Provides beneficiaries the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria.

Effective date.—For provider representation provisions, effective on enactment. For technical denials provisions, effective for coverage denials occurring on or after July 1, 1987.

(b) Prohibition of certain physician incentive plans.—No provision.

(c) Study to develop a strategy for quality review and assurance.—No provision.

Conference agreement

(a) Provider representation of beneficiaries on appeals and appeals of technical denials.—The conference agreement includes the Senate amendment.

(b) Prohibition of certain physician incentive plans.—The conference agreement includes the House provision with an amendment extending its applications to Medicaid. The agreement modifies the House requirement for HMOs and CMPs by extending the period of exemption to April 1, 1989. The Secretary would be required to conduct a study of the impact of physician incentive arrangements and make legislative recommendations to refine the prohibition as it relates to HMOs and CMPs by January 1, 1988. The provision does not apply to incentive plans approved by the Secretary as part of a demonstration project.

(c) Study to develop a strategy for quality review and assurance.—The conference agreement includes the House provision with an amendment concerning coordination of quality of care studies. The Secretary of Health and Human Services (HHS) would be required to designate an office with responsibility for coordinating the planning of studies on quality of care, including the development of priorities for quality studies. The office would also be responsible for coordinating access to data necessary to conduct the studies and for

ient with the Academy for conducting the
my does not submit an acceptable applica-
may request one or more appropriate non-
ies to submit an application to conduct the
er into an arrangement for the study with
bmits the best application.
ry, in developing plans for the conduct of
that consumer and provider groups, peer
the Joint Commission on Accreditation of
societies, and private purchasers of care
xpertise in the monitoring and quality of

tment.

ation of beneficiaries on appeals and appeal
Similar provision, except prohibits provider
y from imposing any financial liability on
nection with representation. Also prohibits
der for representing a beneficiary in an un-
being allowed as reasonable costs.
s the right to appeal payment denials for
hat do not meet the "intermittent or home

provider representation provisions, effective
inical denials provisions, effective for cover-
n or after July 1, 1987.
rtain physician incentive plans.—No provi-

strategy for quality review and assurance.—

tation of beneficiaries on appeals and appeals
—The conference agreement includes the

rtain physician incentive plans.—The confer-
les the House provision with an amendment
ons to Medicaid. The agreement modifies the
HMOs and CMPs by extending the period of
1989. The Secretary would be required to con-
act of physician incentive arrangements and
mendations to refine the prohibition as it re-
MPs by January 1, 1988. The provision does
plans approved by the Secretary as part of a

a strategy for quality review and assurance.—
ment includes the House provision with an
g coordination of quality of care studies. The
nd Human Services (HHS) would be required
with responsibility for coordinating the plan-
lity of care, including the development of pri-
dies. The office would also be responsible for
data necessary to conduct the studies and for

maintaining a clearinghouse on PPS quality studies conducted by HHS and other entities. Such office may be located within the Health Care Financing Administration.

12. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PARTS A AND B (SECTIONS 10224, 4504, AND 4509 OF HOUSE BILL)

Present law

(a) Treatment of group purchasing vendor agreements.—It is prohibited to receive, give, solicit, or offer any remuneration in return for referring or arranging for the furnishing of any item or service or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under Medicare.

Some hospitals and other providers purchase medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions. A service or transactional fee is charged to participating institutions by GPOs. In some situations, fees are also paid by the vendor or supplier in order to participate in the GPO agreement. This practice constitutes a technical violation of Medicare anti-fraud and abuse preventions.

(b) Extension and clarification of competitive contracting authority.—DEFRA provided the Secretary with the authority to enter into two competitively bid contracts under part A and two such contracts under part B to replace poor performing contractors, i.e., intermediaries and carriers. This authority expires on September 30, 1986.

While the Secretary has used this authority to enter into competitively bid cost contracts, competitive bidding has not been used in the negotiation of fixed-price contracts.

(c) Parts A and B COBRA technical corrections.—Current law contains a number of technical errors.

(d) Delay in promulgation of regulations.—The Secretary may at any time issue regulations, instructions to Medicare carriers and fiscal intermediaries, and other instruments which change Medicare policy. Regulations must be issued in final form prior to August 15 or prior to October 6 to be included in the August or October Gramm-Rudman-Hollings baseline. As an exception to this general rule, proposed regulations updating prospective payments for hospital operating costs are included in the August or October Gramm-Rudman-Hollings baseline if they are issued prior to the August 15 or October 6 deadline.

House bill

(a) Treatment of group purchasing vendor agreements.—

Section 10224.—Permits the payment of administrative fees to group purchasing organizations by a vendor if the purchasing agent has an appropriate written contract and full disclosure of the payment is made to each provider.

Section 4594.—Similar provision.

Section 4509.—No provision.

(b) Extension and clarification of competitive contracting authority.—

Section 10224.—Extends the authority of the Secretary for 3 years to enter into competitively bid contracts with intermediaries and contractors to replace poor performing contracts. Language would be clarified to include fixed-price contracting.

Section 4504.—No Provision.

Section 4509.—No Provision.

(c) Parts A and B COBRA technical corrections.—

Section 10224.—Corrects technical errors as follows: (1) clarifies that a 1-year transition period is provided for foreign medical graduates (FMGs) who have not passed the Foreign Medical Graduate Examination in the Medical Sciences from July 1, 1986, through June 30, 1987, such a FMG will be counted at a rate equal to one-half of the rate at which the individual would otherwise be counted; (2) allows the Secretary to announce rather than publish health maintenance organization and competitive medical plan rates by September 7 of each year; (3) clarifies effective date of the provision regarding penalties for billing for assistants at surgery for certain cataract operations; (4) allows temporary use of carrier prepayment screening as a substitute for preprocedure review; (5) clarifies that the termination date of the ACCESS demonstration project is July 31, 1987; and (6) makes other miscellaneous corrections to COBRA and related laws.

Section 4504.—No provision.

Section 4509.—Identical provision.

(d) Delay in promulgation of regulations.—The Secretary would be prohibited from issuing in final form any regulation, instruction, or other policy before September 15, 1987, which is estimated by the Secretary to achieve Medicare savings in fiscal year 1987 of more than $50,000,000, except as required to implement specific provisions required under statute. The Secretary would also be prohibited from publishing in final form any regulation regarding changes in the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under Medicare part A between September 1, 1986 and September 1, 1987. References in current law to regulations issued in final or proposed form pursuant to Sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act would be clarified. Under this provision, no such reference would be construed as including any regulation issued or proposed with respect to capital-related costs.

Effective date.—(a) Applies to payments made before, on, or after the date of enactment; (b) applies to contracts entered into on or after October 1, 1986; (c) applies as if it had been included in the enactment of COBRA; and (d) enactment.

Senate amendment

No provision.

Conference agreement

(a) Group purchasing agreements.—The conference agreement includes the House provision with an amendment. The conference agreement follows section 4504 of the bill which would exclude amounts paid by vendors of goods and services to authorized purchasing agents for groups of hospitals, nursing homes or other enti-

s the authority of the Secretary for 3
petitively bid contracts with interme-
:o replace poor performing contracts.
fied to include fixed-price contracting.
ision.
ision.
echnical corrections.—
ts technical errors as follows: (1) clari-
on period is provided for foreign medi-
o have not passed the Foreign Medical
n the Medical Sciences from July 1,
987, such a FMG will be counted at a
the rate at which the individual would
2) allows the Secretary to announce
th maintenance organization and com-
tes by September 7 of each year; (3)
the provision regarding penalties for
urgery for certain cataract operations;
of carrier prepayment screening as a
ire review; (5) clarifies that the termi-
ESS demonstration project is July 31,
r miscellaneous corrections to COBRA

ision.
l provision.
of regulations.—The Secretary would
n final form any regulation, instruc-
eptember 15, 1987, which is estimated
Medicare savings in fiscal year 1987 of
pt as required to implement specific
itute. The Secretary would also be pro-
final form any regulation regarding
for computing the amount of payment
npatient hospital services under Medi-
per 1, 1986 and September 1, 1987. Ref-
egulations issued in final or proposed
886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4)
ould be clarified. Under this provision,
construed as including any regulation
ect to capital-related costs.
to payments made before, on, or after
pplies to contracts entered into on or
plies as if it had been included in the
) enactment.

ements.—The conference agreement in-
with an amendment. The conference
4504 of the bill which would exclude
goods and services to authorized pur-
hospitals, nursing homes or other enti-

ties and individuals furnishing medicare services. The conference agreement would delete the reference to a specific percentage limit on the amount of such a fee. The deletion was made because of a concern that specifying a percentage might establish a norm for all such fees, resulting in increases in current fees that are typically below the amount specified. The Secretary shall monitor these arrangements for possible abuse, particularly those in excess of 3 percent. In addition, the conference agreement would require disclosure of fees paid by medicare providers as prescribed by the Secretary in regulations.

(b) Competitive contracting.—The conference agreement includes the House provision with an amendment which would clarify the Secretary's authority to enter into competitively bid fixed price contracts.

(c) COBRA technicals.—The conference agreement does not include the House provision.

(d) Moratorium on HCFA regulations.—The conference agreement includes the House provision with an amendment to prohibit the Secretary from issuing any regulation, instruction or other policy regarding hospitals or physicians before September 1, 1987 which would achieve medicare savings of more than $50 million in fiscal year 1988.

The conference agreement also prohibits the Secretary from issuing final regulations that change the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under part A before September 1, 1987.

The agreement also requires that the Secretary allow 60 days for public comment on proposed regulations and notices, except for limited circumstances when such comment periods are not possible due to statutorily imposed deadlines for Secretarial action. This provision does not require the Secretary to provide an opportunity for public comment for items (such as interpretive rules, general statements of policy, or rules of agency organization, procedure or practice) that are not currently subject to that requirement. (See also item #2 and #3).

13. DIRECT COSTS OF GRADUATE MEDICAL EDUCATION (SECTION 4501 OF HOUSE BILL)

Present law

COBRA restructure the manner in which Medicare reimburses teaching hospitals for the direct cost they incur for graduate medical education. Effective with cost reporting periods beginning on or after July 2, 1985, hospitals are to receive payment on the basis of a formula that takes into account each hospital's previous average cost per full-time equivalent resident, the number for full-time equivalent residents during the period for which reimbursement is being made, an the hospital's proportion of total inpatient days used by Medicare patients during that period.

(a) Clarifying counting of time spent in out patient settings. Time spent by residents out of the inpatient setting is counted for this purposes only if the setting is part of the hospital.

(b) Reducing maximum initial residence period.—Beginning on July 1, 1986, distinctions are made among residents, for purposes of

counting their full-time equivalency in this formula, and different weighting factors are applied depending on how many years of resident training they have completed. Residents are weighted at 1.00 during the period needed to obtain their first board eligibility, plus one additional year, not to exceed a total of 5 years. This results in full payments for either 4 or 5 years. After the initial residency period, payments are reduced; beginning on July 1, 1987, payments for such residents are reduced to half (i.e., a weight factor of .50) of what they would otherwise have been.

House bill

(a) Clarifying counting of time spent in outpatient settings.—Counts only time spent in patient care activities towards the determination of full-time equivalency (used in determining of payments for direct graduate medical education costs), and counts all time so spend by a resident under an approved medical residency training program, without regard to the setting in which the activities are performed, if the hospital incurs costs for the training program in that setting.

(b) Reducing Maximum Initial residency period. Reduces the length of the initial residency period from 5 years to 4 years. As a result, the support for the fifth year of residency is reduced by half (i.e., a weighting factor of .50), conforming to policy adopted in COBRA for the sixth and succeeding years.

Provides a one year transition, from July 1, 1987, through June 30, 1988, during which support for the fifth year of residency is reduced by one-quarter (i.e., a weighting factor of .75 instead of .50) for a resident whose support would otherwise be reduced by half.

Effective date.—Applies to payments for approved residency training programs as of July 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Clarifying counting of time spent in outpatient settings.—The conference agreement includes the House provision, with an amendment clarifying that, in order to receive payments under this provision, the hospital must incur all or substantially all of the costs of the residency training in the ambulatory setting. This requirement could be met, for example, if the hospital has an agreement with an independent entity to be legally responsible for reimbursing the entity for the costs the entity incurs for the residency program, subject to the maximum amount recognized as allowable under the Medicare formula enacted in P.L. 99–272, the Consolidated Omnibus Reconciliation Act of 1985.

(b) Reducing maximum initial residency period.—The conference agreement does not include the House provision.

valency in this formula, and different depending on how many years of resi- pleted. Residents are weighted at 1.00 obtain their first board eligibility, plus exceed a total of 5 years. This results or 5 years. After the initial residency d; beginning on July 1, 1987, payments ed to half (i.e., a weight factor of .50) of ave been.

f time spent in outpatient settings.— atient care activities towards the deter- lency (used in determining of payments education costs), and counts all time so in approved medical residency training the setting in which the activities are ncurs costs for the training program in

Initial residency period. Reduces the cy period from 5 years to 4 years. As a ifth year of residency is reduced by half .50), conforming to policy adopted in ıcceeding years.

sition, from July 1, 1987, through June ort for the fifth year of residency is re- a weighting factor of .75 instead of .50) rt would otherwise be reduced by half. to payments for approved residency y 1, 1987.

f time spent in outpatient settings.—The cludes the House provision, with an it, in order to receive payments under must incur all or substantially all of the ning in the ambulatory setting. This re- or example, if the hospital has an agree- entity to be legally responsible for reim- costs the entity incurs for the residency aximum amount recognized as allowable la enacted in P.L. 99–272, the Consolidat- ı Act of 1985.

initial residency period.—The conference le the House provision.

14. COST LIMITS FOR HOME HEALTH AGENCIES (SECTION 4502 OF HOUSE BILL; SECTION 613 OF SENATE AMENDMENT)

Present law

Section 1861(v)(1(L) of the Social Security Act authorizes the Secretary to set limits on home health agency costs which may be recognized as reasonable in the efficient delivery of services. The Secretary is authorized to establish limits for home health agencies at the 75th percentile of the average cost per visit for freestanding home health agencies, or at a lower percentile or comparable or lower limit as the Secretary may determine. The Secretary is also authorized to provide for exemptions and exceptions to these limits as he deems appropriate.

Prior to final regulations published by the Secretary on July 5, 1985, limits to home health agencies were established by regulation at the 75th percentile of the labor-related component of per visit cost and the nonlabor component of per visit cost. Separate limits were established for each type of service (e.g., skilled nursing, home health aide, physical therapy); however they were applied in the aggregate to each home health agency based on its mix of services.

With the regulations published July 5, 1985, HCFA revised the home health limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits were set at 120 percent of the mean labor-related and nonlabor component of per visit costs. For cost reporting periods beginning on or after July 1, 1986, the limits are set at 115 percent of the mean, and for cost reporting periods beginning on or after July 1, 1987, the limits are to be set at 112 percent of the mean. These regulations also established and applied separate limits for each type of service.

House bill

(a) Application of cost limits.—Amends the Secretary's authority to establish limits for home health agency costs to require that limits be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies. The Secretary is also required to base limits on the most recent data available, which may be for cost reporting periods beginning no earlier than October 1, 1983. The Secretary must also take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent these changes in costs are not reflected in available data.

(b) GAO study.—Requires the Comptroller General to study and report to Congress by April 1, 1987, on: (1) the appropriateness and impact on Medicare beneficiaries of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis; and (2) the appropriateness of the percentage limits established in regulation.

Effective date.—Cost reporting periods beginning on or after July 1, 1985.

Requirement for the Secretary to base limits on most recent data available: effective for cost reporting periods beginning on or after July 1, 1985.

Requirement for the Secretary to take into account changes in costs for billing and verification procedures: effective for changes in requirements of Secretary effected before, on, or after July 1, 1985.

Senate amendment

(a) Application of cost limits.—Repeals the Secretary's authority to establish home health limits at the 75th percental of the average per visit cost and replaces it with authority to establish, for the cost reporting periods beginning on or after July 1, 1985, limits at 120 percent of the mean of the labor-related and nonlabor component of per visit costs for freestanding home health agencies; for cost reporting periods beginning on or after July 1, 1986, limits at 115 percent of the mean; and for cost reporting periods beginning on or after July 1, 1987, limits at 112 percent of the mean.

Requires that for cost reporting periods beginning on or after Oct. 1, 1986, limits must be applied on an aggregate basis, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.

(b) GAO study.—Requires the Comptroller General to study and report to Congress, not later than Sept. 1, 1987, on the appropriateness of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis.

Effective date.—Enactment.

Conference agreement

(a) Application of cost limits.—The conference agreement includes the House provision with an amendment changing the effective date to cost reporting periods beginning on or after July 1, 1986.

(b) GAO study.—The conference agreement include the House provision.

15. ESTABLISHMENT OF RESEARCH PROGRAM (SECTION 4503 OF HOUSE BILL; SECTION 616 OF SENATE AMENDMENT)

Present law

No provision.

A growing body of research on the utilization of medical services indicates variations in the scope of care furnished to otherwise comparable populations. Such research raises questions that have a bearing on policy decisions affecting the Medicare program. These include questions about the quality of care, the appropriateness of care, and the cost-effectiveness of care being received by Medicare enrollees and the effects of the payment methodologies and quality assurance measures currently employed.

House bill

(a) Research projects.—Requires the Secretary to provide for a research program on patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness.

The research is required to include (1) assessments of the extent of uncertainty regarding appropriateness; (2) assessments of the appropriateness of admissions or selection criteria; (3) development of

tary to take into account changes in
on procedures: effective for changes in
ected before, on, or after July 1, 1985.

ts.—Repeals the Secretary's authority
ts at the 75th percental of the average
t with authority to establish, for the
ing on or after July 1, 1985, limits at
he labor-related and nonlabor compo-
eestanding home health agencies; for
ing on or after July 1, 1986, limits at
d for cost reporting periods beginning
s at 112 percent of the mean.
orting periods beginning on or after
applied on an aggregate basis, rather
oasis, with appropriate adjustment for
osts of hospital-based agencies.
the Comptroller General to study and
than Sept. 1, 1987, on the appropriate-
ne health agency cost limits on a disci-
an on an aggregate basis.

mits.—The conference agreement in-
ith an amendment changing the effec-
periods beginning on or after July 1,

erence agreement include the House

RCH PROGRAM (SECTION 4503 OF HOUSE
6 OF SENATE AMENDMENT)

h on the utilization of medical services
scope of care furnished to otherwise
h research raises questions that have a
affecting the Medicare program. These
quality of care, the appropriateness of
ess of care being received by Medicare
he payment methodologies and quality
y employed.

uires the Secretary to provide for a re-
utcomes of selected medical treatments
the purpose of assessing their appropri-
iveness.
o include (1) assessments of the extent
opriateness; (2) assessments of the ap-
or selection criteria; (3) development of

improved measures of patient outcome; (4) evaluation of patient outcome; and (5) efforts to reduce existing levels of uncertainty or disagreement regarding appropriateness.

(b) Study priorities.—Requires the Secretary, in selecting treatments and procedures to be studied, to give priority to those medical and surgical treatments and procedures (1) for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographic areas; and (2) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the program and risk involved to the beneficiary.

(c) Funding levels.—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—$4 million for FY 1987, $5 million for FY 1988, and $5 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—$2 million for FY 1987, $2.5 million for 1988, and $2.5 million for FY 1989.

(d) Funding distribution.—Requires not less than 90 percent of each fiscal year's appropriation to be used to fund grants to and cooperative arrangements with, non-Federal research entities. The remaining funds may be used by the Secretary for research by Federal entities and for administrative costs.

(e) Administration.—Requires the research program to be run by the National Center for Health Services Research and Health Care Technology. The Center is required to establish application procedures for grants and cooperative agreements. The Center is required to establish peer review panels to review all such applications and all research findings. The Center is required to consult with the Council on Health Care Technology in establishing the scope and priorities for the research program and shall report periodically to the Council on the status of the program.

(f) HHS cooperation.—Requires the Secretary to make available data derived from the Medicare care program and any other HHS programs for use in the research program.

(g) Report to Congress.—Requires the Center to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations no later than 18 months after enactment, and annually thereafter, on the research program's findings.

(h) dissemination of findings.—Requires the Center, in cooperation with appropriate medical specialty groups, to disseminate the research program's findings as widely as possible, including disseminating the findings, to each peer review organization.

(i) Permitting services to be provided under research program.—Permits exceptions to the "reasonable and necessary" coverage exclusion, as necessary to carry out this research.

Effective date.—October 1, 1986.

Senate amendment

(a) Research project.—Similar provision, except the research is required to include (1) reorganization of data relating to claims under Part A and B in a manner that facilitates research with respect to patient outcomes; (2) assessments of the appropriateness of admis-

sions and discharges; (3) assessments of the extent of professional uncertainty regarding efficacy; (4) development of improved methods for measuring quality-of-life patient outcomes; (5) model evaluations of patients outcomes, and (6) evaluation of the effects on physician's practice patterns of the dissemination to physicians and peer review organizations of the findings of the research in items (2), (3), (4), and (5) above.

(b) Study priorities.—Identical provision.

(c) Funding levels.—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—$3 million for FY 1987, $2.75 million for FY 1988, and $1.75 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—$3 million for FY 1987, $2.75 million for FY 1988; and $1.75 million for FY 1989.

(d) Funding distribution.—Identical provision.

(e) Administration.—Similar provision.

(f) HHS cooperation.—Identical provision.

(g) Report to Congress.—Identical provision.

(h) Dissemination of findings.—Identical provision.

(i) Permitting services to be provided under Research Program.—Identical provision.

Effective date.—October 1, 1986.

Conference agreement

(a) Research projects.—The conference agreement includes the Senate amendment with a modification deleting the role of the Assistant Secretary for Planning and Evaluation.

(b) Study priorities.—The conference agreement includes the Senate amendment.

(c) Funding levels.—The conference agreement includes the House provision.

(d) Funding distribution.—The conference agreement includes the House provision.

(e) Administration.—The conference agreement includes the House provision.

(f) HHS cooperation.—The conference agreement includes the House provision.

(g) Report to Congress.—The conference agreement includes the House provision.

(h) Dissemination of findings.—The conference agreement includes the House provision.

(i). Permitting services to be provided under Research Program.—The conference agreement includes the House provision.

16. CIVIL MONETARY PENALTY AND EXCLUSION PROVISIONS (SECTION 4505 OF HOUSE BILL)

Present law

Practitioners and institutions who present false or certain other improper claims or requests for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Services Block Grant programs are, in addition to potential criminal penalties, subject to civil monetary penalties of up to $2,000 for each item or service and, in lieu of damages, an assessment of up to twice the amount

sessments of the extent of professional
acy; (4) development of improved meth-
f-life patient outcomes; (5) model evalua-
and (6) evaluation of the effects on phy-
of the dissemination to physicians and
of the findings of the research in items

tical provision.
es available, for the purposes of carrying
(1) from the Federal Hospital Insurance
FY 1987, $2.75 million for FY 1988, and
and (2) from the Supplementary Medical
million for FY 1987, $2.75 million for
for FY 1989.
—Identical provision.
ilar provision.
ntical provision.
dentical provision.
ings.—Identical provision.
be provided under Research Program.—

1, 1986.

The conference agreement includes the
modification deleting the role of the As-
ing and Evaluation.
ne conference agreement includes the

e conference agreement includes the

a.—The conference agreement includes

e conference agreement includes the

The conference agreement includes the

The conference agreement includes the

ndings.—The conference agreement in-

be provided under Research Program.—
includes the House provision.

LTY AND EXCLUSION PROVISIONS (SECTION
)5 OF HOUSE BILL)

itions who present false or certain other
sts for reimbursement under the Medi-
al and Child Health Services Block Grant
to potential criminal penalties, subject to
of up to $2,000 for each item or service
in assessment of up to twice the amount

claimed. Civil money penalty proceedings are prosecuted by the Inspector General of the Department of Health and Human Services before an administrative law judge; provider's may appeal adverse determinations to the appropriate U.S. Circuit Court of Appeals. In addition, individuals who have been convicted of criminal offenses related to their participation in Medicare and Medicaid are subject to exclusion from both programs; these individuals are entitled to an administrative hearing and, if the agency upholds the Inspector General's decision to exclude, judicial review.

House bill

(a) Collateral estoppel effect of prior Federal criminal convictions.—In a proceeding to bar a physician or other individual from participating in Medicare or Medicaid which is against an individual who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and which involves the same transaction as in the criminal action, the individual cannot relitigate (i.e., is estopped from denying) the essential elements of the criminal offense in a subsequent civil case including a civil monetary penalties case.

(b) Authority of hearing officer to sanction misconduct.—The official conducting such a hearing may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct that would interfere with the speedy, orderly, or fair conduct of the hearing.

Requires the sanction to reasonably relates to the severity and nature of the failure or misconduct. The sanction may include: (1) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established; (2) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense; (3) striking pleadings, in whole or in part; (4) staying the proceedings; (5) dismissal of the action; (6) entering a default judgment; (7) ordering the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; and (8) refusing to consider any motion or other action which is so filed in a timely manner.

(c) Clarification of exclusion authority for certain offenders.—Considers a physician or other individual to have been "convicted" of a criminal offense: (1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court; (3) when a plea of guilty or nolo contender by the physician or individual has been accepted by a Federal, State, or local court; and (4) when the physician or individual has entered into participation in a first offender or other program when judgment of conviction has been withheld.

Effective date.—(a) Applies on enactment, without regard to when a criminal conviction was obtained; (b) applies to failures or misconduct occurring on or after the date or enactment; and (c) ap-

plies to judgments entered, findings made and pleas entered before, on or after the date of enactment (except for (4) which applies to participation in a program entered into on or after the date of enactment).

Senate amendment

No provision.

Conference agreement

(a) Collateral estoppel effect of prior Federal criminal convictions.—The conference agreement includes the House provision.

(b) Authority of hearing officer to sanction misconduct.—The conference agreement includes the House provision.

(c) Clarification of exclusion authority for certain offenders.—The conference agreement includes the House provision.

17. HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES (SECTION 4508 OF HOUSE BILL)

Present law

Current law does not include requirements with regard to hospitals and organ procurement protocols, or with respet to certification standard for organ procurement agencies.

The Task Force on Organ Transplantation, created by the National Organ Transplant Act (P.L. 98–507), found that opportunities for obtaining organs were lost due to shortcommings in the present organ procurement process. The Task Force recommended legislation requiring that hospitals establish protocols for encouraging organ and tissue donation and requiring certification standards for organ procurement agencies.

House bill

(a) Hospital protocols.—Requires that the Secretary provide that no hospital may participate in Medicare or Medicaid unless the hospital has established protocols for encouraging organ and tissue donation.

(b) Criteria and certification of organ procurement agencies.—Would prohibit payment under Medicare or Medicaid with respect to costs of procuring organs, by an organ procurement organization that is not qualified under section 317(b) of the Public Health Service Act (or does not meet the standards to be qualified), and that has not been certified (and recertified at least every 2 years) as meeting the standards established by the Association of Independent Organ Procurement Agencies.

Effective date.—Applies to hospitals as of July 1, 1987, and to the costs of organs procured on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

(a) Hospital protocols.—The conference agreement includes the House provision, with amendments. In addition to establishing protocols for making a routine inquiry, hospitals would have to notify

d, findings made and pleas entered before,
nactment (except for (4) which applies to
n entered into on or after the date of en-

effect of prior Federal criminal convic-
greement includes the House provision.
g officer to sanction misconduct.—The con-
ies the House provision.
'usion authority for certain offenders.—The
cludes the House provision.

FOR ORGAN PROCUREMENT AND STANDARDS
NT AGENCIES (SECTION 4508 OF HOUSE BILL)

include requirements with regard to hospi-
nent protocols, or with respect to certifica-
procurement agencies.
'rgan Transplantation, created by the Na-
Act (P.L. 98-507), found that opportunities
re lost due to shortcommings in the present
:ess. The Task Force recommended legisla-
spitals establish protocols for encouraging
on and requiring certification standards for
ıcies.

.—Requires that the Secretary provide that
:ipate in Medicare or Medicaid unless the
l protocols for encouraging organ and tissue

'ification of organ procurement agencies.—
ıt under Medicare or Medicaid with respect
gans, by an organ procurement organization
der section 371(b) of the Public Health Serv-
eet the standards to be qualified), and that
(and recertified at least every 2 years) as
established by the Association of Independ-
t Agencies.
lies to hospitals as of July 1, 1987, and to the
d on or after January 1, 1988.

ils.—The conference agreement includes the
amendments. In addition to establishing pro-
outine inquiry, hospitals would have to notify

the local organ procurement agency when a potential organ donor is identified. The conferees intend for the hospital and the organ procurement agency to cooperate in counseling and procurement activities.

Those hospitals in which organ transplants are performed would also have to be members of the national organ transplant network established under the National Organ Transplant Act of of 1984, and to comply with the policies of that network regarding the allocation of organs.

The requirement that these procedures be followed in cases of a potential tissue donor who is not also a potential organ donor has been removed. Instead, a definition or "organ" is added, which provides the Secretary discretion to extend these requirements to any tissue that the Secretary finds to be appropriate. This provision encourages tissue donation whenever the hospital has identified a potential organ donor. The hospital is required, under the conference agreement, to notify the organ procurement agency designated by the Secretary to serve that area. In turn, the organ procurement agency, under the terms of the conference agreement and the requirements of the National Organ Transplant Act, is required to have cooperative arrangements with tissue banks, in order to be designated by the Secretary as the organ procurement agency for the area.

(b) Criteria and Certification of Organ Procurement Agencies.—The conference agreement includes the House provision with an amendment. In order for its costs to be recongized by medicare, an organ procurement agency would have to comply with the requirements of section 371(b) of the Public Health Service Act, which were enacted as part of the National Organ Transplant Act of 1984. The alternative of meeting standards established by the Association of Independent Organ Procurement Agencies is deleted.

The conference agreement also adds several other requirements that agencies must meet. First, they must meet performance standards set by the Secretary, respecting the quality or competence of the services performed by the agency and the volume of organs procured.

Second, with respect to all organs within their control, they must comply with the policies established by the national organ transplant network regarding the allocation or organs, irrespective of whether the organ is placed through the network or is placed without the assistance of the network. This provision reflects the conferees' concern about wastage and criticisms of the allocation of available organs.

The conferees understand that the national network will have policies requiring that separate lists of potential recipients be maintained for U.S. residents and foreign nationals, and that all potential recipients on the first list be reviewed for an acceptable match between organ and recipient before the organ is offered to someone on the second list or exported out of the country. It is also the conferees' understanding that these policies require there to be documentation that an acceptable match was not available on either list before the organ was offered for export. The conference agreement is premised on these policies being retained and fol-

lowed, and on all allocations being made on the basis of criteria established by the network.

Medicare payments will be made for organ procurement agencies only for those agencies specifically designated by the Secretary, and only one agency may be designated in each service area.

18. MEDICARE AS SECONDARY PAYER; COVERAGE REQUIREMENTS FOR CERTAIN OTHER PAYERS (SECTION 611 OF SENATE AMENDMENT)

Present law

TEFRA required employers to offer their employees ages 65 through 69 the same group health plans to employees under age 65. When the employee age 65 to 69 elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the right not to elect such coverage and to be covered only by Medicare. DEFRA extended this provision to include beneficiaries covered under a working spouse's employer-based group health insurance plan when the working spouse is under age 65. COBRA further extended the provision to apply to the working aged and spouses over age 69.

House bill

No provision.

Senate amendment

Recodifies current law with respect to secondary payer provisions and amends the Social Security Act to provide that Medicare would be the secondary payer for all Medicare beneficiaries (including disabled and those who buy into Medicare[1] who elect to be covered by employment based health insurance as a current employee (or family member of such employee) of a large employer. This provision would explicitly include under the secondary payer provision those persons with group health coverage who are the employer, former employees under age 65, individuals associated with the employer in a business relationship, or members of the families of any such persons.

Uniform rules are established as to the benefits Medicare pays when other payers are primary but do not pay the full charge. Payments under workers compensation or liability or related insurance are counted toward the Medicare deductible, as provided under current law for other types of primary payers.

The secondary payer provisions are enforceable through private action or action brought by the Federal Government (with double damages payable). In addition, a tax is imposed on employers and employee organizations that contribute to plans that do not conform with the secondary payer provisions. The tax is 25 percent of the employer's or employee organization's annual contributions to nonconforming group health plans.

Federal Medicaid payments to a State would be reduced by an amount equal to 25 percent of the group health plan expenses of a State that does not comply with the secondary payer provision.

Conforming amendments are made to the section relating to special enrollment periods and premium penalties for part B of Medicare for individuals covered under employer based group health plans.

s being made on the basis of criteria es-

e made for organ procurement agencies
ecifically designated by the Secretary,
designated in each service area.

Y PAYER; COVERAGE REQUIREMENTS FOR SECTION 611 OF SENATE AMENDMENT)

ers to offer their employees ages 65
health plans to employees under age
65 to 69 elects such coverage, Medicare
er. The beneficiary retains the right not
to be covered only by Medicare. DEFRA
include beneficiaries covered under a
r-based group health insurance plan
under age 65. COBRA further extended
e working aged and spouses over age 69.

th respect to secondary payer provisions
rity Act to provide that Medicare would
all Medicare beneficiaries (including dis-
to Medicare) who elect to be covered by
insurance as a current employee (or
ployee) of a large employer. This provi-
de under the secondary payer provision
health coverage who are the employer,
e 65, individuals associated with the em-
nship, or members of the families of any

lished as to the benefits Medicare pays
nary but do not pay the full charge. Pay-
ensation or liability or related insurance
dicare deductible, as provided under cur-
primary payers.
visions are enforceable through private
y the Federal Government (with double
tion, a tax is imposed on employers and
at contribute to plans that do not con-
ayer provisions. The tax is 25 percent of
e organization's annual contributions to
th plans.
ents to a State would be reduced by an
t of the group health plan expenses of a
with the secondary payer provision.
s are made to the section relating to spe-
d premium penalties for part B of Medi-
ed under employer based group health

Effective date.—The special enrollment period and premium penalty provisions apply to enrollments occurring on or after October 1, 1986, and premiums for months beginning on or after October 1, 1986. All other provisions apply to items and services furnished in calendar quarters beginning on or after October 1, 1986.

Conference agreement

The conference agreement includes the Senate amendment with modifications. The provision which requires that medicare be secondary payer for disabled beneficiaries who elect to be covered under employer-based health insurance as a current employee (or family member of such employee) would only appiy to employers with 100 or more employees. The provision would sunset October 1, 1991. The agreement would require the Secretary to study the impact of this provision. The agreement includes additional modifications to (1) retain enforcement of the requirements related to coverage of the working aged under the Age Discrimination Act, (2) add a private right of action to enforce the provision for the aged, and (3) eliminate reductions in Medicaid funds as a penalty for States which do not comply.

19. COVERAGE OF SERVICES OF NURSE ANESTHETISTS (SECTIONS 4524 AND 10207(A) OF HOUSE BILL)

Present law

Payments for services of certified registered nurse anesthetists (CRNAs) employed by hospitals are made to the hospital on a reasonable cost basis and are temporarily excluded from the definition of operating costs under PPS. For services of CRNAs employed by anesthesiologists, the anesthesiologist is paid on a reasonable charge basis as if he had performed the service. Physicians who provide medical direction for CRNAs employed by a hospital receive an adjusted reasonable charge payment. Provisions relating to payment for services of hospital-employed and physician-employed CRNAs are both effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

House bill

(a) Payment extension.—

Section 10207(a).—Extends current payment provisions for the services of CRNAs hospital-employed for cost-reporting periods beginning before October 1, 1988. [Note: See item 23(c) for related provision requiring study of prospective payment for radiology, anesthesia, and pathology services.]

Section 4524.—No provision.

(b) Direct reimbursement for services of a registered nurse anesthetist.—

Section 10207(a).—No provision.

Section 4524.—Authorizes direct reimbursement for anesthesia services and related care furnished by a registered nurse anesthetist which he/she is legally authorized to perform in the State. The term registered nurse anesthetist is defined as a registered nurse licensed by the State who meets such education, training, and other requirements relating to anesthesia

services and related care as the Secretary may prescribe. The Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.

Specifies that nothing in this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.

Authorizes direct reimbursement for services equal to 80 percent of the reasonable charge for such services. The reasonable charge is the amount determined by the Secretary to be consistent with efficient and high quality anesthesia services taking into account the prevailing rate for such services. However, the reasonable charge must be adjusted to the extent necessary to ensure that the total amount paid for such services by Medicare in any fiscal year may not exceed the total amount which would have been paid if such services were included as inpatient hospital services and paid for under Part A, in the same manner as payment was made in fiscal year 1986, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

Requires the Secretary to adjust the reasonable charge for medical direction of services of registered nurse anesthetists to the extent necessary to ensure that the total amount paid for medical direction and services would not exceed the amount which would have been paid in the absence of this provision. If the adjustment results in a reduction in the reasonable charge for a non-participating physician, such physician may not charge more than 125 percent of the adjusted prevailing charge; if the physician charges more, the physician would be required to refund the excess to the individual. If the physician knowingly and willfully imposes charges or fails to make required refunds, the Secretary could impose sanctions.

Effective date.—Section 10207(a).—Enactment. Section 4524.—Applies to items and services furnished on or after October 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Payment extension.—The conference agreement includes the House provision contained in Section 10207(a).

(b) Direct reimbursement for services of a certified registered nurse anesthetist.—The conference agreement includes the House provision contained in Section 4524 with a modification as follows. The conference agreement authorizes payments to be made in an amount equal to the lower of 80% of a fee schedule established by the Secretary or 80% of the actual charge. The Secretary could utilize time units, or a system of base and time units, or another appropriate methodology, in establishing the schedule. The Secretary is permitted to establish a nationwide fee schedule or to adjust the fee schedule for geographic areas. Initially, the fee schedule would be established at a level based on the costs of anesthesia services provided by certified registered nurse anesthetists determined from audited cost data from cost reporting periods ending in FY 85. The

are as the Secretary may prescribe. The
same requirements as those established
ation for the certification of nurse anes-

this section shall contravene provisions
practice of medicine or nursing or State
tutional requirements regarding the ad-
and its medical direction or supervision.
ursement for services equal to 80 percent
or such services. The reasonable charge is
the Secretary to be consistent with effi-
esthesia services taking into account the
ervices. However, the reasonable charge
xtent necessary to ensure that the total
vices by Medicare in any fiscal year may
unt which would have been paid if such
inpatient hospital services and paid for
manner as payment was made in fiscal
into account changes in prices and tech-
inistration of anesthesia.
to adjust the reasonable charge for medi-
of registered nurse anesthetists to the
e that the total amount paid for medical
uld not exceed the amount which would
ience of this provision. If the adjustment
he reasonable charge for a non-participat-
cian may not charge more than 125 per-
vailing charge; if the physician charges
l be required to refund the excess to the
cian knowingly and willfully imposes
required refunds, the Secretary could

10207(a).—Enactment. Section 4524.—Ap-
es furnished on or after October 1, 1987.

—The conference agreement includes the
l in Section 10207(a).
t for services of a certified registered nurse
nce agreement includes the House provi-
4524 with a modification as follows. The
uthorizes payments to be made in an
r of 80% of a fee schedule established by
he actual charge. The Secretary could uti-
m of base and time units, or another ap-
establishing the schedule. The Secretary
a nationwide fee schedule or to adjust the
ic areas. Initially, the fee schedule would
based on the costs of anesthesia services
stered nurse anesthetists determined from
st reporting periods ending in FY 85. The

fee schedule amount would be adjusted annually by the change in the Medicare economic index.

The fee schedule amount would be adjusted to the extent necessary to ensure that the total amount paid by Medicare (plus applicable coinsurance amounts) in 1989 for certified registered nurse anesthetist services would equal the amount which would be paid under part A for the same volume of CRNA services in the absence of this provision. The Secretary would also be permitted to adjust payment levels in 1989 and 1990 for CRNA services and for medical direction provided by physicians (or both), in order to assure that payments made under this provision for both CRNA services and medical direction do not exceed those that would be made in the absence of this provision. The Secretary could do this by adjusting time or base units, or by any other means. The conferees recognize that it will be difficult to document the volume and cost of CRNA services currently being reimbursed under Part B and to estimate what total Medicare payments would be in the absence of this provision. The Secretary is expected to use the best estimates available for this purpose.

In the case of nonparticipating physicians whose actual charges have been reduced pursuant to this provision, a special limit on maximum allowable actual charges (MACC) would apply. For the first year the reduction is in effect, the maximum allowable actual charge for the service would equal 125% of the reduced prevailing charge amount plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the reduced prevailing charge amount. In the second year, the special maximum allowable charge for the service would equal 125% of the reduced prevailing charge amount.

Certified registered nurse anesthetists would be required to accept assignment for all Medicare services and civil monetary penalties could be imposed for violations of this requirement. Payments could be made directly to the certified registered nurse anesthetist. Alternatively, the hospital or physician could bill for and receive payment for these services where an employment relationship or contract so stipulates. The hospital or physician could not bill more for certified registered nurse anesthetist services than the amount the CRNA could bill directly.

The conference agreement specifies that the fee schedule would apply to items and services furnished on or after January 1, 1989. The current cost pass through for hospital-employed CRNAs would be extended to that date, irrespective of the hospital's cost reporting period. The conferees intend that the Secretary will extend the limitation on physicians' rights to bill for inpatient services provided by CRNAs whom they employ, as provided under current law until January 1, 1989.

II. Medicare Provisions (Part B)

20. Extension of premium payment provision through 1989 (section 10231 of House bill; section 1001(c) of Senate amendment)

Present law

Under the original Medicare law, beneficiary premiums paid for 50 percent of the program cost of part B with the remaining 50 percent financed by Federal general revenues. However, between 1974 and 1982 the law limited the percentage increase in the part B premium to the percentage increase in Social Security cash benefits payments. By 1982, beneficiary premiums paid for approximately 25 percent of program costs.

TEFRA, as amended by the Social Security Amendments of 1983 (P.L. 98–21), specified that enrollee premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. If there is no Social Security COLA, the monthly premium would not be increased in that year. If the amount of a premium increase is greater than the Social Security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's Social Security check. Disabled enrollees pay the same premiums, though the per capita cost of services to these enrollees is higher. DEFRA extended this provision for 1986 and 1987, COBRA extended this provision through 1988. Beginning January 1, 1989, the premium calculation reverts to the earlier method.

House bill

(a) One year extension.—Extends the current 25 percent payment provision for one additional year, through calendar year 1989.

(b) Technical conforming change.—No provision.

Effective date.—Enactment.

Senate amendment

(a) One year extension.—No provision.

(b) Technical conforming change.—Makes technical clarifying changes in provision reducing the premium increase where necessary to avoid a reduction in the individual's Social Security checks.

Effective date.—Applies with respect to monthly premiums for months after December 1986.

Conference agreement

(a) One year extension.—The conference agreement does not include the House provision.

(b) Technical conforming change.—See Item 1, Part I, Income Security Provisions.

ARE PROVISIONS (PART B)

1 PAYMENT PROVISION THROUGH 1989 (SEC-
ILL; SECTION 1001(C) OF SENATE AMEND-

licare law, beneficiary premiums paid for
cost of part B with the remaining 50 per-
general revenues. However, between 1974
the percentage increase in the part B pre-
increase in Social Security cash benefits
ficiary premiums paid for approximately
its.
the Social Security Amendments of 1983
at enrollee premiums in 1984 and 1985
ase to amounts necessary to produce pre-
5 percent of program costs for elderly en-
ial Security COLA, the monthly premium
n that year. If the amount of a premium
he Social Security COLA, the premium in-
as to avoid a reduction in the individual's
isabled enrollees pay the same premiums,
st of services to these enrollees is higher.
provision for 1986 and 1987, COBRA ex-
ough 1988. Beginning January 1, 1989, the
erts to the earlier method.

—Extends the current 25 percent payment
nal year, through calendar year 1989.
ng change.—No provision.
ment.

—No provision.
ning change.—Makes technical clarifying
ducing the premium increase where neces-
n in the individual's Social Security checks.
es with respect to monthly premiums for
1986.

—The conference agreement does not in-
on.
ing change.—See Item 1, Part I, Income Se-

21. PAYMENTS FOR PHYSICIANS' SERVICES (SECTIONS 10232 (A–D, AND F–J) AND SECTION 4525 OF HOUSE BILL; SECTIONS 621(B–C) AND 622 OF SENATE AMENDMENT)

Present law

Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service or the prevailing charge for the service in the community. The prevailing charge for a service is the lower of the 75th percentile of customary charges for the service in the area, or the maximum allowed prevailing charge, which is the unadjusted prevailing charge in a base year increased by the Medicare economic index (MEI).

DEFRA froze physician fees for the 15-month period July 1, 1984 through September 30, 1985. P.L. 99-107, as amended, and COBRA extended this freeze through April 30, 1986 for participating physicians and December 31, 1986 for non-participating physicians.

Since July 1, 1984, the actual charges of non-participating physicians have been subject to a freeze. Violations have been subject to sanctions. The freeze expires on December 31, 1986.

On May 1, 1986, participating physicians received an increase in prevailing charges based on the MEI for 1986 plus an additional one percentage point. The one percentage point increase is temporary and will not be included after December 31, 1986. Participating and non-participating physicians will receive a prevailing charge increase each year beginning on January 1987. The increase for non-participating physicians is to be lagged and will be based on the MEI for the preceding year.

The MEI, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels. On August 12, 1986, the Administration has by regulation revised the calculation of the MEI to account for an adjustment to the housing cost component, which the Administration believes to be historically overstated. The index would be computed retroactively using the rental equivalence housing component of the CPI as a substitute for the home ownership approach.

COBRA required the Secretary, with the advice of the newly established Physician Payment Review Commission, to develop a relative value scale for physician payments. The Secretary is required to complete the development of the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

(a) Maximum allowable prevailing charges.—

Section 10232.—On January 1, 1987, all physicians will receive an increase in prevailing charges based on the percentage increase in the Medicare economic index (MEI) for services provided in 1987. The increase will apply to the maximum allowable prevailing charges of participating and nonparticipating physicians respectively in effect during the 8-month period ending on December 31, 1986. The Secretary is required to treat the maximum allowed prevailing charges recognized for participating and nonparticipating physicians respectively

during such 8-month period as having been justified by economic changes. In years subsequent to 1987, the maximum allowed prevailing charges of participating and nonparticipating physicians is to be increased by the MEI increase factor applicable for services provided during the year.

Section 4525.—Specifies that the one percentage point increase for participating physicians permitted on May 1, 1986 is built into the MEI base for future calculations. Allows an MEI update for all participating physicians and all assigned claims submitted by nonparticipating physicians. Limits increases in prevailing charges for unassigned claims to 1 percent in 1987.

(b) Bonus for participating physicians.—

Section 10232.—Provides that in applying the percentage increase in the MEI for physicians' services furnished by participating physicians during each year after 1986, the Secretary shall provide for a bonus of one percentage point in the percentage increase otherwise determined. Such a bonus for each year will apply to physicians' services furnished only during the year and not in the calculation of payments for any subsequent year.

Section 4525.—No provision.

(c) Limit on actual charges for nonparticipating physicians.—

Section 10232.—The current freeze on actual charges of nonparticipating physicians would be replaced by a role of increase limit. In 1987, nonparticipating physicians could increase their actual charges above levels in effect during the calendar quarter beginning April 1, 1984 by an amount equal to the MEI for 1987 plus one percentage point. For nonparticipating physicians without actual charges for a procedure during the calendar quarter beginning April 1, 1984, the limit is the 50th percentile of customary charges (weighted by frequency of the procedure) for the procedure performed by nonparticipating physicians in the locality during the 12-month period ending June 30, 1986 increased by the MEI for 1987 plus one percentage point. In future years, the limit is the maximum allowed charge permitted for the previous year increased by the percentage increase in the MEI. If the physician knowingly and willfully bills for actual charges in excess of permitted charges, the Secretary may apply sanctions for noncompliance. Carriers are required to provide available information to nonparticipating physicians to enable them to determine maximum allowed charges.

In calculating customary charges for services furnished on or after January 1, 1988, the Secretary shall not recognize any increases in actual charges in excess of these limits.

Section 4525.—Similar provision with respect to monitoring of charges and application of sanctions. Nonparticipating physicians could increase their actual charges in 1987 by the percentage increase in the MEI for assigned claims and only by 1 percent for nonassigned claims. In calculating customary charges for services furnished during 1988 and 1989, the Secretary shall not recognize any increase in actual charges in excess of the limits.

(d) Medicare economic index (MEI).—

eriod as having been justified by eco-
s subsequent to 1987, the maximum al-
s of participating and nonparticipating
ased by the MEI increase factor appli-
ed during the year.

es that the one percentage point in-
physicians permitted on May 1, 1986 is
for future calculations. Allows an MEI
ting physicians and all assigned claims
ipating physicians. Limits increases in
inassigned claims to 1 percent in 1987.

physicians.—
ies that in applying the percentage in-
hysicians' services furnished by partici-
g each year after 1986, the Secretary
us of one percentage point in the per-
ise determined. Such a bonus for each
sicians' services furnished only during
calculation of payments for any subse-

vision.

for nonparticipating physicians.—
urrent freeze on actual charges of non-
would be replaced by a role of increase
ipating physicians could increase their
vels in effect during the calendar quar-
984 by an amount equal to the MEI for
ige point. For nonparticipating physi-
arges for a procedure during the calen-
April 1, 1984, the limit is the 50th per-
arges (weighted by frequency of the pro-
e performed by nonparticipating physi-
ring the 12-month period ending June
the MEI for 1987 plus one percentage
, the limit is the maximum allowed
ne previous year increased by the per-
MEI. If the physician knowingly and
charges in excess of permitted charges,
y sanctions for noncompliance. Carriers
available information to nonparticipat-
e them to determine maximum allowed

ary charges for services furnished on or
he Secretary shall not recognize any in-
es in excess of these limits.
r provision with respect to monitoring
ion of sanctions. Nonparticipating phy-
heir actual charges in 1987 by the per-
MEI for assigned claims and only by 1
ed claims. In calculating customary
nished during 1988 and 1989, the Secre-
ze any increase in actual charges in

lex (MEI).—

Section 10232.—Prohibits the Secretary from revising the MEI in a manner that provides for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index.

Section 4525.—Identical provision.

(e) Reasonable charge limitations.—(See item 21, Inherent Reasonableness.)

(f) Recruiting.—

Section 10232.—Requires carriers to implement programs to recruit and retain physicians as participating physicians, including educational and outreach activities and the use of professional relations personnel to handle billing problems for participating physicians. Carriers are also required to implement programs to familiarize beneficiaries with the participating physician program and to assist them in locating participating physicians. The Secretary is required to provide a system for measuring carriers' performance with respect to these responsibilities or those specified under section 1842(h) of the Social Security Act. An incentive pool, equal to 1 percent of total payments to carriers for claims processing, will be available to reward carriers for their success in increasing the percentage of participating physicians in the carrier's service area.

Section 4525.—No provision.

(g) Directories of participating physicians.—

Section 10232.—Requires the Secretary to provide that each appropriate area directory is sent to each Part B beneficiary residing in the area and that an appropriate number of copies is sent to hospitals in the area. The copies are to be sent free of charge.

Requires each directory to provide alphabetical listings for: (1) all participating physicians in the area; and (2) locality and specialty of such physicians.

Section 4525.—No provision.

(h) Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier.—

Section 10232.—Provides that, where a physician has provided services on a nonassigned basis which are determined by a peer review organization or carrier to be unnecessary, the physician is required to refund any amounts collected from the beneficiary within 30 days after receiving a notice that the services were unnecessary or within 15 days after receiving notice of an adverse determination upon reconsideration or appeal. A refund would not be required if: (i) the physician did not know and could not reasonably have been expected to have known that the services would be found to be unnecessary; or (ii) the beneficiary was informed in advance that Medicare payment would not be made for a specific service and agreed to pay for the service. Physicians who knowingly and willfully fail to make required refunds on a timely basis would be subject to civil money penalties and/or exclusion from the Medicare program. Carriers and peer review organizations would be

required to send denial notices based on medical necessity determinations to the physician and the beneficiary.

Section 4525.—No provision.

(i) Maintenance and use of participating directories by hospitals.—

Section 10232.—Amends Medicare participation agreements to require hospitals to make available directories of participating physicians and, where referral is made to a nonparticipating physician, inform the beneficiary of such fact. Wherever practicable, the hospital must identify at least one qualified participating physician.

Section 4525.—No provision.

(j) Submission and disclosure of information on unassigned claims.—

Section 10232.—Provides that where the actual charge on an unassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, and the excess of the physician's actual charge over the approved charge. A physician failing to comply with this requirement would be required to refund payments received in excess of the Medicare approved charge. Knowing and willful failures to make required refunds would be subject to civil money penalties and/or exclusion from Medicare.

Section 4525.—No provision.

(k) HCFA common procedure coding system.—No provision.

(l) Recommendations for relative value scale (RVS).—No provision

Effective date.—Section 10232: (a) and (c) apply to services furnished on or after January 1, 1987. (b) and (d) are effective on enactment. (f) applies to carrier contracts as of October 1, 1987; carrier bonus payments shall be first paid not later than April 1, 1988, to reflect performance of carriers during November 1987. (g) applies for distribution of directories to beneficiaries for 1988 directories; organization of directories applies to 1987 directories. (h) applies to services furnished on or after October 1, 1987. (i) applies to agreements as of October 1, 1987. (j) applies to surgical procedures performed on or after October 1, 1987.

Section 4525: (a) and (c) applies to services furnished on or after January 1, 1987. (d) effective on enactment.

Senate amendment

(a) Maximum allowable prevailing charges.—No provision.

(b) Bonus for participating physicians.—No provision.

(c) Limit on actual charges for nonparticipating physicians.—No provision.

(d) Medicare economic index (MEI).—Provides that the adjustment of the MEI as proposed by the Administration would be made in two stages, with one-half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The Secretary is required to utilize the rule-making process for proposed changes in the methodology, basis, or elements of the MEI.

(e) Reasonable charge limitations.—(See item 21, Inherent Reasonableness.)

iial notices based on medical necessity de-
physician and the beneficiary.
provision.
use of participating directories by hospi-

nends Medicare participation agreements
o make available directories of participat-
where referral is made to a nonparticipat-
n the beneficiary of such fact. Wherever
pital must identify at least one qualified
an.
provision.
isclosure of information on unassigned

ovides that where the actual charge on an
urgical procedure exceeds $500, the physi-
isclose to the individual in writing, the es-
estimated approved charge, and the excess
tual charge over the approved charge. A
comply with this requirement would be re-
rments received in excess of the Medicare
nowing and willful failures to make re-
d be subject to civil money penalties and/
edicare.
provision.
edure coding system.—No provision.
or relative value scale (RVS).—No provi-

10232: (a) and (c) apply to services fur-
ry 1, 1987. (b) and (d) are effective on en-
rrier contracts as of October 1, 1987; carri-
be first paid not later than April 1, 1988,
f carriers during November 1987. (g) ap-
irectories to beneficiaries for 1988 directo-
ctories applies to 1987 directories. (h) ap-
d on or after October 1, 1987. (i) applies to
r 1, 1987. (j) applies to surgical procedures
tober 1, 1987.
) applies to services furnished on or after
tive on enactment.

prevailing charges.—No provision.
ing physicians.—No provision.
rges for nonparticipating physicians.—No

index (MEI).—Provides that the adjust-
osed by the Administration would be made
half of the adjustment becoming effective
other half January 1, 1988. The Secretary
rule-making process for proposed changes
, or elements of the MEI.
limitations.—(See item 21, Inherent Rea-

(f) Recruiting.—No provision.
(g) Directories of participating physicians.—No provision.
(h) Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier.—No provision.
(i) Maintenance and use of participating directories by hospitals.—No provision.
(j) Submission and disclosure of information on unassigned claims.—No provision.
(k) HCFA common procedure coding system.—Requires by July 1, 1987, the consolidation of the payment methodology under HCFA's Common Procedures Coding System (HCPCS) and mandates its use for hospital outpatient services by the same date. Carriers and intermediaries are required to report services and claims using HCPCS by January 1, 1988.

Recommendations for relative value scale (RVS).—Requires the Secretary in making recommendations for application of an RVS to: 1) develop and assess an appropriate index to reflect justifiable geographic variations in practice costs without exacerbating the geographic maldistribution of physicians; and 2) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas. The Secretary is to take into account recommendations of the Physician Payment Review Commission. The Secretary is to develop an interim geographic index by July 1, 1987, and collect data for refining the index by December 31, 1989. The date of the Secretary is required to report on the RVS is deferred to July 1, 1989. The potential application date of the RVS is deferred until after December 31, 1989.

Effective date.—Enactment.

Conference agreement

(a) Maximum allowable prevailing charges.—The conference agreement includes the House provision with amendments. All physicians would receive an increase in their prevailing charges equal to 3.2% effective January 1, 1987. In 1987 and future years, the percent increase in the MEI would be applied to the maximum allowable prevailing charges for participating and nonparticipating physicians respectively in effect on December 31 of the previous year.

The conference agreement makes permanent the current differential in the prevailing charges of participating and nonparticipating physicians. In other words, the prevailing charges for nonparticipating physicians would equal 96% of the prevailing charges for participating physicians. In future years, participating and nonparticipating physicians would receive the same percentage increase based on the percentage increase in the medicare economic index (MEI) for the year. This provision replaces the 1-year lag in prevailing charges for nonparticipating physicians contained in the Consolidated Omnibus Budget Reconciliation Act of 1985.

The conference agreement does not include the House provision that would pay a higher rate for assigned claims of nonparticipating physicians.

(b) Bonus for participating physicians.—The conference agreement does not include the House provision that would provide a

new bonus for participating physicians in addition to the differential in effect during the 8-month period ending December 31, 1986.

(c) Limit on actual charges for nonparticipating physicians.—The conference agreement includes the House provision with a modification as follows. In the case of a nonparticipating physician whose actual charge for a service in the previous year equals or exceeds 115% of the prevailing charge for nonparticipating physicians for the service in the current year, the maximum allowable actual charge (MAAC) is 101% of the physician's actual charge for the previous year.

A nonparticipating physician whose actual charge for a service in the previous year is less than 115% of the current year prevailing charge for nonparticipating physicians could increase his/her actual charge in the current year by the greater of: (i) 1% above the physician's previous year actual charge or (ii) an amount based on a comparison between the physician's MAAC for the previous year and 115% of the current year prevailing charge. Under clause (ii), the MAAC for the current year equals the previous year MAAC increased by a fraction of the difference between 115% of the current year prevailing and the previous year MAAC. The applicable fractions are one-quarter, one-third, one-half, and one for 1987, 1988, 1989, and 1990 respectively.

Thus, for calendar year 1987, the physician's MAAC for 1986 is compared with the prevailing charge for nonparticipating physicians in 1987. The 1987 MAAC is equal to the 1986 MAAC plus one-quarter of the difference between 115% of the 1987 prevailing charge amount and the 1986 MAAC. For example, if a physician's 1986 MAAC is $100 and 115% of the 1987 prevailing charge amount is $124, the 1987 MAAC for that physician for that service is $106 [$100+0.25 ($124−$100)].

In future years a similar calculation is made. In 1988, the MAAC equals the 1987 MAAC plus one-third fo the difference between 115% of the nonparticipating physicians' 1988 prevailing charge amount and the 1987 MAAC. In 1989, the MAAC equals the 1988 MAAC plus one-half of the difference between 115% of the 1989 prevailing charge amount and the 1988 MAAC. In 1990 the MAAC equals 115% of the 1990 prevailing charge. The limitation on maximum allowable actual charges expires on December 31, 1990 or one year after submission by the Secretary to the Congress of the required report on relative value scales, whichever occurs earlier.

Because of the July 1, 1984 through December 31, 1986 freeze on actual charges of nonparticipating physicians, a nonparticipating physician's 1986 MAAC equals the physician's April 1 through June 30, 1984 base period charges. The 1986 MAAC for a nonparticipating physician who does not have an actual charge for a service during the April to June 1984 base period is set at the 50th percentile of customary charges for the service as provided by nonparticipating physicians in the locality during the 12 month period ending on June 30, 1986. A similar rule applies in future years.

The conference agreement does not require a physician to have a single actual charge for a service. Instead, a physician may have a range of actual charges above the MAAC provided that there are offsetting charges below the MAAC. However, if the weighted average of the physician's actual charges for a procedure during a

:ing physicians in addition to the differen-
8-month period ending December 31, 1986.
irges for nonparticipating physicians.—The
ıcludes the House provision with a modifi-
case of a nonparticipating physician whose
ice in the previous year equals or exceeds
charge for nonparticipating physicians for
ent year, the maximum allowable actual
: of the physician's actual charge for the

ıysician whose actual charge for a service
less than 115% of the current year prevail-
cipating physicians could increase his/her
rrent year by the greater of: (i) 1% above
year actual charge or (ii) an amount based
en the physician's MAAC for the previous
ırrent year prevailing charge. Under clause
e current year equals the previous year
fraction of the difference between 115% of
ling and the previous year MAAC. The ap-
ne-quarter, one-third, one-half, and one for
90 respectively.
ear 1987, the physician's MAAC for 1986 is
evailing charge for nonparticipating physi-
7 MAAC is equal to the 1986 MAAC plus
rence between 115% of the 1987 prevailing
1986 MAAC. For example, if a physician's
and 115% of the 1987 prevailing charge
37 MAAC for that physician for that service
4 – $100)].
illar calculation is made. In 1988, the MAAC
C plus one-third fo the difference between
cipating physicians' 1988 prevailing charge
MAAC. In 1989, the MAAC equals the 1988
of the difference between 115% of the 1989
unt and the 1988 MAAC. In 1990 the MAAC
0 prevailing charge. The limitation on maxi-
charges expires on December 31, 1990 or one
by the Secretary to the Congress of the re-
ve value scales, whichever occurs earlier.
1, 1984 through December 31, 1986 freeze on
participating physicians, a nonparticipating
AC equals the physician's April 1 through
iod charges. The 1986 MAAC for a nonparti-
) does not have an actual charge for a service
une 1984 base period is set at the 50th per-
harges for the service as provided by nonpar-
in the locality during the 12 month period
86. A similar rule applies in future years.
ement does not require a physician to have a
or a service. Instead, a physician may have a
ges above the MAAC provided that there are
ow the MAAC. However, if the weighted aver-
's actual charges for a procedure during a

period of time exceeds the MAAC, the physician may be subject to civil monetary penalties.

The conference agreement requires that the carriers provide each nonparticipating physician with a list of MAACs for the procedures most commonly provided by the physician at the beginning of each year. It is expected that the list should be sent to each nonparticipating physician no later than March 1 for 1987 and no later than February 1 for subsequent years. While the conferees believe that it is important to provide this information, failure to receive MAACs at the beginning of a year should not be a defense in any action against a physician for failure to abide by the limits.

(d) Medicare economic index.—The conference agreement includes the House provision with amendments. The MEI update for 1987 is set by statute at 3.2%. The Secretary would be required to determine the percentage increase in the MEI on an annualized basis comparing appropriate year-to-year economic changes. For 1988, the MEI update should reflect economic changes comparing the period July 1, 1986 through June 30, 1987 with the period July 1, 1985 through June 30, 1986. (This comparison reflects the same comparisons that would be made under the current MEI methodology.)

The Secretary would be prohibited from revising the cumulative MEI on a retrospective basis. This is accomplished (i) by requiring the Secretary to recognize that the maximum allowable prevailing charges for participating physicians in effect on December 31, 1986 were justified by economic changes and (ii) by requiring use of the annualized MEI comparing appropriate year-to-year economic changes.

The Secretary would be required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner for physicians providing servcie to medicare beneficiaries. The Secretary would be required to consult appropriate experts in conducting the study.

The Secretary would be precluded from changing the methodology used to determine the MEI until completion of the study and publication of a final notice changing the methodology. The new methodology must not reflect retrospective historical adjustments in the cumulative index. The Secretary would be required to publish a proposed notice and allow not less than 60 days for public comment. Until publication of the final notice, the Secretary would be required to use the general methodology that was used to calculate the MEI that was published in the Federal Register on September 30, 1985.

(e) Reasonable charge limitations.—(See item 22.)

(f) Recruiting.—The conference agreement includes the House provision.

(g) Directories of participating physician.—The conference agreement includes the House provision with an amendment. Annually, a letter reminding beneficiaries of the participating physician program and offering a copy of the participating physician directory would be sent to each beneficiary in the beneficiary's Social Security check. The letter would indicate that a free copy of the directory would be sent upon request and the beneficiary would be directed to contact his local Medicare carrier or social security office.

(h) Prohibiting unassigned billing of services determined to be medically unnecessary by a carrier of PRO.—The conference agreement includes the House provision with an amendment specifying that the requirement only applies to covered services with are determined to have been medically unnecessary in the particular case.

(i) Maintenance and use of participating directories by hospitals.—The conference agreement includes the House provision.

(j) Submission and disclosure of information on unassigned claims.—The conference agreement includes the House provision with an amendment which indicates that the information is not to be used as the basis for or evidence in a civil suit.

(k) HCFA common procedure coding system.—The conference agreement includes the Senate amendment with amendments. The Secretary would be required to consult with appropriate experts including physicians and health economists to provide assistance in determining which procedure codes should be consolidated (and in what manner) for payment purposes. The Secretary would be required to publish a proposed notice in the Federal Register and allow 60 days for public comment.

(l) Recommendations for relative value scale.—The conference agreement includes the Senate amendment.

22. INHERENT REASONABLENESS; PAYMENTS FOR CATARACT SURGERY (SECTION 10232(E), SECTION 4526 AND SECTION 4527 OF HOUSE BILL; SECTION 621(A) OF SENATE AMENDMENT)

Present law

(a) Reasonable charge limits inherent reasonableness.—COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness" which are to be used for determining Medicare payments. On August 11, 1986, the Administration by regulation published "inherent reasonableness" guidelines.

There is no authority under current law for the Secretary to limit the actual charges billed by a physician or supplier to protect the beneficiary against increased expenses when Medicare payments are reduced.

(b) Payments for cataract surgery.—Payments for cataract surgery are made on the basis of reasonable charges. Payments for anesthesia services are based on a method that combines base units (with values assigned to each procedure) and time units.

If the Secretary were to reduce Medicare payments for these services, under "inherent reasonableness," he would not have authority to limit the actual charge billed to the patient.

House bill

(a) Reasonable charge limits/inherent reasonableness.—

Section 10232.—

(i) Specifies that for nonphysicians' services, the inherent reasonableness limitation may be used only by carriers and only in calculating prevailing charges for an item or service by eliminating charges for specific items or services in specific instances in which the charges, in comparison

l billing of services determined to be carrier of PRO.—The conference agreeovision with an amendment specifying pplies to covered services with are dedically unnecessary in the particular

*of participating directories by hospi*nent includes the House provision.

losure of information on unassigned reement includes the House provision ndicates that the information is not to idence in a civil suit.

dure coding system.—The conference ate amendment with amendments. The to consult with appropriate experts inth economists to provide assistance in e codes should be consolidated (and in purposes. The Secretary would be red notice in the Federal Register and ment.

relative value scale.—The conference ate amendment.

ESS; PAYMENTS FOR CATARACT SURGERY N 4526 AND SECTION 4527 OF HOUSE BILL; AMENDMENT)

nits inherent reasonableness.—COBRA romulgate regulations which specify exerent reasonableness" which are to be are payments. On August 11, 1986, the on published "inherent reasonableness"

nder current law for the Secretary to led by a physician or supplier to protect creased expenses when Medicare pay-

surgery.—Payments for cataract surgery asonable charges. Payments for anesthemethod that combines base units (with cedure) and time units.

o reduce Medicare payments for these reasonableness," he would not have auharge billed to the patient.

its/inherent reasonableness.—

for nonphysicians' services, the inherlimitation may be used only by carriers ating prevailing charges for an item or cing charges for specific items or services es in which the charges, in comparison

with the charges for similar items and services, are grossly excessive or deficient.

(ii) Prohibits the Secretary, through regulations, guidelines, instructions or otherwise, from requiring carriers to reduce payment amounts for specific items or services for which the Secretary had made a specific determination that the payment amounts or charges are excessive.

(iii) Requires the Secretary, after consultation with the Physician Payment Review Commission, to submit to Congress by April 1, 1987, recommendations concerning payment-reductions for overpriced items and services. The recommendations are to include the specific payment reductions recommended and measures to assure that reductions in payment do not result in corresponding increases in out-of-pocket costs to Medicare beneficiaries.

Section 4526.—

(i) Requires the Secretary before exercising the authority to adjust reasonable charges, to make specific findings. Specifies that the Secretary may compare: charges and resource costs for related procedures; charges and resource costs for the procedure over a period of time; charges for procedures in different geographic areas; and charges and allowed payments by Medicare and other payers. An adjustment on the basis of a comparison of prevailing charges in different localities may only be made if the Secretary determines that the prevailing charge allowed in one locality is grossly out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. Specifies that the Secretary, in determining whether to adjust payment rates, shall consider the following: potential impacts on quality, access and beneficiary liability of the adjustment; likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians; proportion of such procedures for which payment is available under Medicare; and the prevailing charge of other third-party payers for the procedure.

(ii) Specifies that the Secretary is required to consult with the Physician Payment Review Commission with respect to a proposed adjustment, and after such consultation, publish a notice of the proposed adjustment and allow for public comment. The final notice must explain the factors and data taken into consideration in making the adjustment and respond to any comments made by the Physician Payment Review Commission.

(iii) Provides that if the adjustment results in a reduction in the reasonable charge for a nonparticipating physician, the physician may not charge the beneficiary more than 125 percent of the adjusted prevailing charge. Any excess amounts must be refunded. The Secretary may impose sanctions in the case of violations.

(b) Payments for Cataract Surgery.—

Section 4527.—

(i) Places a limit on prevailing charges for cataract surgery with intraocular lens implantation equal to 110% of the prevailing charge recognized for such surgery without the lens implant. In determining the reasonable charge for cataract surgery anesthesia, the Secretary may not recognize more than 4 base units (as used for purposes of determining anesthesia payments on the date of enactment).

(ii) Specifies that non-participating physicians may not charge more than 125% of the adjusted prevailing charge for cataract surgery with lens implantation and cataract surgery anesthesia. If the physician charges more he/she shall refund any excess amounts. The Secretary may impose sanctions in the case of physicians who knowingly and willfully impose excess charges or fail to make refunds.

Effective date.—(a) Effective on enactment. (b) Applies to services furnished on or after January 1, 1987.

Senate amendment

(a) Reasonable charge limits/inherent reasonableness.—

Section 10232.—

(i) No provision.

(ii) Specifies that the inherent reasonableness authority must be applied through regulation for physicians and prohibits carriers from acting independently, without the issuance of regulations.

(iii) Requires the Secretary, by October 1, 1987 to review the inherent reasonableness of reasonable charges for each of the 10 most costly procedures paid for under part B, determined on the basis of aggregate annual payments. The Secretary may review additional procedures.

Section 4526.—

(i) Specifies the factors to consider in determining the inherent reasonableness of charges. The identified factors would include cases where: prevailing charges are significantly different from those in comparable localities; Medicare and Medicaid are the main sources of payment; the marketplace for the service is not truly competitive because of the limited number of physicians performing the service; there have been increases in charges not explained by inflation; charges do not reflect changing technology or reductions in acquisition or production costs, or the prevailing charges are substantially higher than payments made by other purchasers. Regional differences in fees are to be taken into account unless there is substantial economic justification for a uniform national fee or payment limit.

(ii) Similar provision. Specifies that the proposed notice must explain factors and data taken into consideration and evaluate the impact on the accessibility of and beneficiary liability for the service. Provides that the Commission shall comment on the proposed rule during the public comment period.

(iii) No provision.

n prevailing charges for cataract sur-
r lens implantation equal to 110% of
e recognized for such surgery without
determining the reasonable charge for
sthesia, the Secretary may not recog-
e units (as used for purposes of deter-
ayments on the date of enactment).
non-participating physicians may not
25% of the adjusted prevailing charge
with lens implantation and cataract
If the physician charges more he/she
xcess amounts. The Secretary may
the case of physicians who knowingly
e excess charges or fail to make re-

e on enactment. (b) Applies to services
y 1, 1987.

s/inherent reasonableness.—

the inherent reasonableness authority
ugh regulation for physicians and pro-
acting independently, without the issu-

Secretary, by October 1, 1987 to review
bleness of reasonable charges for each
procedures paid for under part B, de-
is of aggregate annual payments. The
w additional procedures.

ctors to consider in determining the in-
ss of charges. The identified factors
where: prevailing charges are signifi-
n those in comparable localities; Medi-
are the main sources of payment; the
service is not truly competitive be-
number of physicians performing the
een increases in charges not explained
do not reflect changing technology or
sition or production costs, or the pre-
substantially higher than payments
nasers. Regional differences in fees are
count unless there is substantial eco-
or a uniform national fee or payment

on. Specifies that the proposed notice
s and data taken into consideration
pact on the accessibility of and benefi-
e service. Provides that the Commis-
on the proposed rule during the public

(b) Payments for cataract surgery.—No provision.

Effective date.—Applies to final regulations promulgated after July 1, 1986; required review by Secretary effective on enactment.

Conference agreement

(a) Reasonable charge limits inherent reasonableness.—The conference agreement includes the Senate provision and the House provision in Section 4526 with modifications as follows:

Under the inherent reasonableness authority, the Secretary would be authorized to establish a payment level for a physician service based on considerations other than the actual, customary, or prevailing charge for the service. A departure from the standard methodology would be appropriate under a number of circumstances, including the following: (i) the prevailing charge for a service in a particular locality is significantly in excess of, or below, the prevailing charge for the same service in other comparable localities taking into account the relative costs of furnishing the service: (ii) medicare and medicaid are the sole or primary sources of payment for the service; (iii) the marketplace for the service is not truly competitive; (iv) there have been increases in charges for a service that cannot be explained by inflation or technology; (v) the charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs; (vi) the prevailing charge for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

The Secretary would be authorized to make an adjustment in payment is such adjustment is justified on the basis of an appropriate comparison of resource costs or charges. An adjustment may be based on one of the following types of comparison: (i) a comparison between charges and resource costs for related procedures; (ii) a comparison between charges and resource costs for the procedure over a period of time; (iii) a comparison between charges for a procedure in different geographic areas; and (iv) a comparison between charges and allowed payments for a procedure under this part and by other payers. The term "resource costs" includes factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

Adjustments based on comparisons of charges for a procedure in different geographic areas may be made only if the Secretary determines that the prevailing charge allowed in a locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. The Secretary would not be authorized to establish a uniform fee or payment limit under this provision unless the Secretary determines that there is substantial economic justification for a uniform fee or a uniform payment limit. Such justification would have to be explained in a proposed and final notice.

In determining whether to adjust payments rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the

likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.

The Secretary would be required to consult with representatives of physicans likely to be affected at an appropriate stage in the process. The Secretary would also be required to publish a proposed notice: (i) specifying the charge or methodology proposed to be established, (ii) explaining the factors and data on which the proposal is based and (iii) explaining the potential impacts on quality, access, and beneficiary liability. After publication of the proposed notice, the Secretary would be required to allow 60 days folr public comment. The Physician Payment Review Commission would be required to comment on the proposal, and the Secretary would be required to take into account the comments made by the Commission and by the public in making a final determination. The final notice shall explain the factors and data that the Secretary took into consideration in making a final determination and must include and respond to the comments made by the Commission.

If an adjustment is made that results in a reduction in the payments allowed for a service, a special limit on actual charges for nonparticipating physicians would apply. The purpose of this special limit is to moderate beneficiary liability for charges in excess of the medicare approved charge. For the first year the reduction is in effect, the maximum allowable actual charge for the service equals 125% of the inherently reasonable charge level plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the inherently reasonable charge level. In the second year, the special maximum allowable charge for the service equals 125% of the inherently reasonable charge level.

The Secretary is required to review payments under this section for 10 of the most costly procedures paid for under Part B. The secretary should have flexibility in choosing the procedures in terms of those for which modifications might be the most cost effective. If the Secretary determines that for one or more of such overpriced procedures that a payment adjustment cannot be made pursuant to this section, he shall report recommendations to Congress concerning appropriate statutory changes.

(b) Payments for cataract surgery.—The conference agreement includes the House provision with amendments. The maximum allowable prevailing charges for participating and nonparticipating physicians providing cataract surgery would be cut by 10% effective January 1, 1987. The maximum allowable prevailing charges would be cut by an additional 2% effective January 1, 1988. In no case could the reduced amount be lower than 75% of the weighted national average prevailing charge amounts. The Secretary would be required to issue in final form the proposed notice which was published on August 15, 1986 in the Federal Register which would require that carriers recognize no more than 4 base units for anesthesia services provided during cataract surgery.

By ratifying the regulations relating to payment limits for anesthesia services, the Congress does not intend that the Secretary be restricted in his authority to subsequently revise these regulations.

Nonparticipating physicians providing cataract surgery services and cataract surgery anesthesia would be required to reduce their

nt rates, reasonable charge reductions on
articipation rates of physicians.
required to consult with representatives
affected at an appropriate stage in the
uld also be required to publish a proposed
charge or methodology proposed to be es-
he factors and data on which the proposal
ining the potential impacts on quality,
ability. After publication of the proposed
ld be required to allow 60 days folr public
Payment Review Commission would be re-
e proposal, and the Secretary would be re-
nt the comments made by the Commission
ing a final determination. The final notice
and data that the Secretary took into con-
final determination and must include and
made by the Commission.
ade that results in a reduction in the pay-
vice, a special limit on actual charges for
ans would apply. The purpose of this spe-
beneficiary liability for charges in excess
l charge. For the first year the reduction is
1 allowable actual charge for the service
ently reasonable charge level plus one-half
n the physician's actual charge in the pre-
of the inherently reasonable charge level.
special maximum allowable charge for the
he inherently reasonable charge level.
ired to review payments under this section
procedures paid for under Part B. The sec-
ibility in choosing the procedures in terms
fications might be the most cost effective. If
es that for one or more of such overpriced
ent adjustment cannot be made pursuant to
port recommendations to Congress concern-
y changes.

ract surgery.—The conference agreement in-
ision with amendments. The maximum al-
rges for participating and nonparticipating
ataract surgery would be cut by 10% effec-
The maximum allowable prevailing charges
ditional 2% effective January 1, 1988. In no
amount be lower than 75% of the weighted
illing charge amounts. The Secretary would
final form the proposed notice which was
5, 1986 in the Federal Register which would
cognize no more than 4 base units for anes-
during cataract surgery.
ulations relating to payment limits for anes-
ngress does not intend that the Secretary be
rity to subsequently revise these regulations.
ysicians providing cataract surgery services
anesthesia would be required to reduce their

actual charges for these services effective January 1, 1987 pursuant to the method described under paragraph (a).

23. END STAGE RENAL DISEASE PROGRAM AMENDMENTS (SECTIONS 10233, 4506, AND 4507 OF HOUSE BILL, SECTION 623 OF SENATE AMENDMENT)

Present law

The End-Stage Renal Disease Program (ESRD) provides coverage for the cost of routine maintenance dialysis for persons with chronic kidney (renal) failure.

(a) Composite rate for dialysis treatment.—The Secretary shall provide by regulation for a method of reimbursing facilities for routine maintenance dialysis care. Such method provides for the prospective determination of rates based on a single composite weighted formula which takes into account the mix of patients receiving dialysis services at home or in a facility and which reflects the relative costs of providing dialysis services in such settings. The Secretary may provide for exceptions to the prospective payment rates as may be warranted, such as for sole facilities located in isolated rural areas.

In regulations published on May 13, 1983 (effective August 1, 1983), the Secretary established a prospective reimbursement rate for dialysis facilities. The reimbursement rates are calculated on per-treatment base rates (adjusted for wage differences) of $122.91 for independent facilities and $126.76 for hospital-based facilities. On May 13, 1986, the Secretary published a proposed rule that would reduce the base rates to $113.47 for independent facilities and $117.89 for hospital-based facilities.

(b) Payment for physician's services.—Physicians are reimbursed for services related to routine maintenance dialysis care on the basis of a monthly capitation fee that encourages the use of home dialysis.

The regulations establishing the payment rates for physicians were based, in part, on the assertion that the physician could oversee the dialysis care of ten home patients in the same amount of time as seven facility patients, resulting in a facility to home physician treatment capability ratio of 1 to 1.4 in the determination of the composite rate. On March 19, 1986, the Secretary published a proposed rule, based on GAO study, that would change the facility to home physician treatment capability ratio to 1 to 3.9. On July 2, 1986, this change was published as a final rule, effective August 1, 1986. This change will result in an estimated reduction of physicians' average monthly capitation payments for dialysis care from $187.88 to $173.07.

(c) Study of dialysis payment rates.—No provision.

(d) Coverage of immunosuppressive drugs.—Medicare provides coverage for kidney and heart transplants, including organ procurement costs, hospitalization, surgical fees, and immunosuppressive drugs provided in the hospital or administered by a physician.

(e) Reorganization of ESRD network areas.—The Secretary shall establish renal disease network areas and such network organizations (including a coordinating council and medical review boards) for the purpose of assuring the effective and efficient administra-

tion of the ESRD program. The Secretary has established 32 network areas. Under COBRA, the Secretary may consolidate the number of network areas to not less than 14. The Secretary is proposing through regulations to reduce the number of network areas to 14 and to modify the current functions of the networks.

(f) Patient representation on councils and medical review boards.—At least one patient representative shall serve as a member of each network coordinating council and executive committee.

(g) Responsibilities of network organizations.—The network organizations are responsible for: encouraging use of appropriate treatment settings, developing criteria, standards and network goals with respect to quality and appropriateness of treatment, evaluating procedures by which facilities assess appropriateness of treatment, identifying facilities not cooperating in achieving network goals, and submitting to the Secretary by July 1 of each year an annual report.

(h) Facility cooperation with networks.—The Secretary may terminate or withhold certification of facilities that consistently fail to cooperate with network plans and goals.

(i) Maximum use of vocational rehabilitation services.—It is the intent of Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable for home dialysis or transplantation should be so treated.

(j) National end stage renal disease registry.—The Secretary shall submit to Congress an annual report on the ESRD program.

(k) Funding of ESRD network organizations.—No provision.

(l) Reuse of dialysis filters and other dialysis supplies.—No provision.

House bill

(a) Composite rate for dialysis treatment.—

Section 10233.—Permits the Secretary to adjust the composite rates to dialysis facilities, but only if the base rate for dialysis in an independent facility is not less than $117.50 per treatment and only if the base rate for hospital-based facilities is not less than $121.50 per treatment. An application for a payment exception for sole facilities located in isolated rural areas shall be deemed approved unless the Secretary disapproves it by not later than 45 working days after the request for the exception is filed.

Section 4506.—Similar provision except that it adds pediatric dialysis facilities as a basis for payment exception requests, and applies 45 day deadline to all exception requests.

(b) Payment for physicians' services.—

Section 10233.—Requires the Secretary to implement the changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986.

Section 4506.—Provides that the Secretary shall establish a home to facility physician treatment capability ratio such that the average monthly capitation payment to physicians (based on a weighted average by State ESRD population) would be reduced to $180.00. Such adjustment is to be made such that it would apply to services rendered on or after August 1, 1986.

(c) Study of dialysis payment rates.—

m. The Secretary has established 32 net-
RA, the Secretary may consolidate the
to not less than 14. The Secretary is pro-
is to reduce the number of network areas
irrent functions of the networks.
tion on councils and medical review
patient representative shall serve as a
coordinating council and executive com-

etwork organizations.—The network orga-
for: encouraging use of appropriate treat-
g criteria, standards and network goals
nd appropriateness of treatment, evaluat-
facilities assess appropriateness of treat-
es not cooperating in achieving network
the Secretary by July 1 of each year an

with networks.—The Secretary may ter-
ication of facilities that consistently fail to
lans and goals.
cational rehabilitation services.—It is the
he maximum practical number of patients
lly, and psychologically suitable for home
n should be so treated.
enal disease registry.—The Secretary shall
nual report on the ESRD program.
etwork organizations.—No provision.
ers and other dialysis supplies.—No provi-

lialysis treatment.—
its the Secretary to adjust the composite
s, but only if the base rate for dialysis in
s not less than $117.50 per treatment and
r hospital-based facilities is not less than
n application for a payment exception for
isolated rural areas shall be deemed ap-
tary disapproves it by not later than 45
equest for the exception is filed.
r provision except that it adds pediatric di-
s for payment exception requests, and ap-
ll exception requests.
ans' services.—
uires the Secretary to implement the
monthly capitation payments for dialysis
n the Federal Register on July 2, 1986.
des that the Secretary shall establish a
n treatment capability ratio such that the
ation payment to physicians (based on a
ate ESRD population) would be reduced to
t is to be made such that it would apply to
after August 1, 1986.
yment rates.—

Sections 10233 and 4506.—The Secretary shall provide for a study to evaluate the effectiveness of reductions in payment rates for facility and physician dialysis services and report to Congress not later than January 1, 1988. The Secretary is required to request the National Academy of Sciences to submit an application to conduct the study. If the Academy does not submit an acceptable proposal, the Secretary may request other appropriate entities to submit applications to conduct the study.

(d) Coverage of immunosuppressive drugs.—

Section 10233.—No provision.

Section 4506.—Provides that immunosuppressive drugs furnished to a transplant patient within 1 year of the transplant would be a covered service under part B of Medicare.

(e) Reorganization of ESRD network areas.—

Sections 10233 and 4507.—Requires the Secretary to establish not less than 17 ESRD network areas, and to designate a network administrative organization that includes a network council of dialysis and transplant facilities in the area, and a medical review board. The Secretary shall develop standards, criteria and procedures for evaluating whether to enter into, continue or terminate an agreement with the network administrative organization. The Secretary may terminate such agreements only after applying such standards and finding that the organization has failed to perform its prescribed responsibilities. In the case of a termination, the Secretary may select a successor organization on the basis of competitive bidding. The Secretary shall designate the network areas not later than January 1, 1987. In first designating the network administrative organizations for the areas so established, the Secretary shall designate the current network organizations (or voluntary combinations of such organizations) unless such organizations do not meet the standards established.

(f) Patient representation of councils and medical review boards.—

Sections 10233 and 4507.—Requires at least one patient representative on each network council and each medical review board.

(g) Responsibilities of network organizations.—

Sections 10233 and 4507.—Amends the responsibilities of the network organizations to include in addition to current law functions: encouraging participation of patients, providers, and facilities in vocational rehabilitation programs, setting standards and criteria for such participation, reporting to the Secretary on facilities and providers not providing appropriate care, implementing a patient grievance process, conducting onsite review of facilities and providers, collecting and analyzing data to report to the Secretary, and providing data to assure maintenance of the National ESRD Registry.

(h) Facility cooperation with networks.—

Sections 10233 and 4057.—Adds failure to follow the recommendations of the medical review board as a basis for the Secretary to terminate or withhold certification.

(i) Maximum use of vocational rehabilitation services.—

Sections 10233 and 4507.—Amends current provision to include that the maximum number of patients who are suitable for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment.

(j) National end stage renal disease registry.—

Section 10233.—Requires the Secretary to establish a national end stage renal disease registry using data from networks, transplant centers and other sources that will permit: preparation of the Annual Report to Congress, analysis of the economic impact and medical efficacy of alternative treatment modalities, evaluation of the allocation of resources for treatment and research and measurement of patient mortality and morbidity rates and other indices of quality of care over time. The Secretary shall provide for the appointment of a professional advisory group and will report to Congress on the progress made in establishing such registry not later than January 1, 1987, and establish the registry by January 1, 1988.

Section 4507.—Similar provision.

(k) Funding of ESRD network organizations.—

Section 10233.—Requires the Secretary to reduce the composite rates paid to facilities by $0.50 per treatment (adjusted for modalities of treatment other than hemodialysis) and to provide for payment of such amounts to the network organization for the area in which the treatment is rendered to provide for the administrative costs of the networks.

Section 4507.—Similar provision.

(l) Reuse of dialysis filters and other dialysis supplies.—

Sections 10233 and 4507.—Requires the Secretary to establish protocols on standards and conditions for the reuse of dialysis filters for those facilities and providers who voluntarily elect to reuse such filters. The Secretary shall study the appropriateness of establishing protocols for reuse of other dialysis supplies and, where appropriate, the Secretary may establish such protocols. The protocols established are to be incorporated into the requirements of participation for facilities. Failure to follow such protocols may result in denial of participation or denial of payment for services not in compliance with such protocols.

The Secretary shall establish the protocol on filter reuse not later than January 1, 1988 and shall report to Congress on the need for other such protocols by January 1, 1988.

Effective date.—Enactment except for the following:

(a) Payment provision applies to services rendered on or after October 1, 1986. Exception provision applies to exception applications filed on or after October 1, 1986.

(b) August 1, 1986, for section 4516.

(d) Applies to immunosuppressive drugs provided on or after October 1, 1986.

(e) (f), (g) and (h) No later than January 1, 1987.

(k) Applies to treatment furnished on or after January 1, 1987.

d 4507.—Amends current provision to in-
mum number of patients who are suitable
ɔilitation services be given access to such
ıged to return to gainful employment.
renal disease registry.—
equires the Secretary to establish a nation-
lisease registry using data from networks,
ınd other sources that will permit: prepara-
Report to Congress, analysis of the econom-
al efficacy of alternative treatment modali-
ıe allocation of resources for treatment and
ırement of patient mortality and morbidity
ices of quality of care over time. The Secre-
or the appointment of a professional adviso-
eport to Congress on the progress made in
egistry not later than January 1, 1987, and
y by January 1, 1988.
nilar provision.
network organizations.—
equires the Secretary to reduce the compos-
cilities by $0.50 per treatment (adjusted for
ment other than hemodialysis) and to pro-
f such amounts to the network organization
ich the treatment is rendered to provide for
costs of the networks.
nilar provision.
ilters and other dialysis supplies.—
nd 4507.—Requires the Secretary to estab-
andards and conditions for the reuse of dial-
ɔse facilities and providers who voluntarily
filters. The Secretary shall study the appro-
ɔlishing protocols for reuse of other dialysis
re appropriate, the Secretary may establish
e protocols established are to be incorporated
ents of participation for facilities. Failure to
ɔols may result in denial of participation or
for services not in compliance with such pro-

] establish the protocol on filter reuse not
, 1988 and shall report to Congress on the
ɔtocols by January 1, 1988.
ictment except for the following:
rovision applies to services rendered on or
986. Exception provision applies to exception
on or after October 1, 1986.
986, for section 4516.
mmunosuppressive drugs provided on or after

1) No later than January 1, 1987.
treatment furnished on or after January 1,

Senate amendment

(a) Composite rate for dialysis treatment.—Prohibits the Secretary from reducing the current prospective payment dialysis rates prior to October 1, 1986. The Secretary is required to reduce the prospective payment dialysis rates by $1 for services rendered on or after October 1, 1986 and before October 1, 1988, and is prohibited from further reducing the rates during this period.

(b) Payment for physicians' services.—Same provision as Section 10233 of the House bill.

(c) Study of dialysis payment rates.—The Comptroller General shall conduct a study of facility payment rates for dialysis services and report to Congress not later than September 30, 1987.

(d) Coverage of immunosuppressive drugs.—No provision.

(e) Reorganization of ESRD network areas.—No provision.

(f) Patient representation on councils and medical review board.—No provision.

(g) Responsibilities of network organizations.—No provision.

(h) Facility cooperation with network organizations.—No provision.

(i) Maximum use of vocational rehabilitation services.—No provision.

(j) National end stage renal disease registry.—No provision.

(k) Funding of ESRD network organizations.—No provision.

(l) Reuse of dialysis filters and other dialysis supplies.—No provision.

Effective date.—Enactment.

Conference agreement

(a) Composite rate for dialysis treatment.—The conference agreement includes the Senate amendment with a modification requiring the Secretary to reduce the base rate for calculating the prospective payment by $2 for services furnished on or after October 1, 1986. The Secretary must maintain that rate for two years and would be authorized to change the rate thereafter. The conference agreement includes section 4506 of the House bill's exceptions provision, with an amendment providing sixty, rather than forty-five, working days for the approval or disapproval requirement of exceptions requests.

(b) Payment for physicians' services.—The conference agreement does not include the House provision or Senate amendment. The Administration's changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986, remains effective as published.

(c) Study of dialysis payment rates.—The conference agreement includes the House provision.

(d) Coverage of immunosuppressive drugs.—The conference agreement includes the House provision.

(e) Reorganization of ESRD network areas.—The conference agreement includes the House provision with an amendment deleting the preference for existing networks in awarding competitive contracts. To allow for an orderly transition, the existing network organizations will remain in operation until thirty days after the new network organizations begin operation.

(f) Patient representation on councils and medical review boards.—The conference agreement includes the House provision.

(g) Responsibilities of network organizations.—The conference agreement includes the House provision.

(h) Facility cooperation with networks.—The conference agreement includes the House provision.

(i) Maximum use of vocational rehabilitation services.—The conference agreement includes the House provision.

(j) National end stage renal disease registry.—The conference agreement includes the House provision.

(k) Funding of ESRD network organizations.—The conference agreement includes the House provision, with amendments. The preference for existing networks is deleted. It is also clarified that the competitive bidding for the establishment of new networks includes price competition. In determining which applicant will be awarded the network contract, the Secretary may not weight the price of the bid by more than 20% and must weight the quality and scope factors by at least 80%. The conferees intend that the new funding mechanism is to cover the necessary costs of the existing networks until 30 days after the new networks begin operating.

(l) Reuse of dialysis filters and other dialysis supplies.—The conference agreement includes the House provision with an amendment. The Secretary shall impose standards and conditions for safe and effective dialyzer reuse and reprocessing, enforceable as a condition of medicare participation effective October 1, 1987. Beginning January 1, 1988, no reuse of blood lines, transducers, caps and other accessories shall be allowed in Medicare certified ESRD facilities until and unless standards and conditions for safe reuse and reprocessing of these devices and equipment are imposed as a condition of participation.

Effective dates.—The conference agreement includes the House provision, except the designation of the network areas is to be completed by May 1, 1987 and the new networks are to be established by July 1, 1987.

24. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B (SECTIONS 10234 AND 4531 OF HOUSE BILL)

Present law

(a) Additional members for Physician Payment Review Commission.—The Physician Payment Review Commission established by COBRA consists of 11 commissioners. The Commission was established to provide recommendations concerning physician reimbursements under part B. Commission members are appointed by the Director of the Office of Technology Assessment.

(b) Effective date on voluntary disenrollment from Medicare.—A beneficiary's coverage period under part B can be terminated by filing a notice that he or she no longer wishes to participate or by nonpayment of premiums. When a beneficiary files a notice to disenroll from part B, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed; a termination for nonpayment of premiums takes effect with the end of a grace period (not more than 90 days).

tion on councils and medical review
agreement includes the House provision.
network organizations.—The conference
louse provision.
n with networks.—The conference agree-
provision.
cational rehabilitation services.—The con-
es the House provision.
renal disease registry.—The conference
louse provision.
network organizations.—The conference
House provision, with amendments. The
etworks is deleted. It is also clarified that
for the establishment of new networks in-
In determining which applicant will be
ntract, the Secretary may not weight the
e than 20% and must weight the quality
least 80%. The conferees intend that the
is to cover the necessary costs of the exist-
ys after the new networks begin operating.
lters and other dialysis supplies.—The con-
ides the House provision with an amend-
ll impose standards and conditions for safe
use and reprocessing, enforceable as a con-
icipation effective October 1, 1987. Begin-
reuse of blood lines, transducers, caps and
be allowed in Medicare certified ESRD fa-
standards and conditions for safe reuse and
vices and equipment are imposed as a con-

conference agreement includes the House
signation of the network areas is to be com-
and the new networks are to be established

DMENTS AND MISCELLANEOUS PROVISIONS
(SECTIONS 10234 AND 4531 OF HOUSE BILL)

ers for Physician Payment Review Commis-
ayment Review Commission established by
commissioners. The Commission was estab-
mendations concerning physician reimburse-
Commission members are appointed by the
f Technology Assessment.
voluntary disenrollment from Medicare.—A
period under part B can be terminated by
or she no longer wishes to participate or by
ms. When a beneficiary files a notice to dis-
effective date of the termination is the close
following the calendar quarter in which the
nation for nonpayment of premiums takes
grace period (not more than 90 days).

(c) Study on prospective payment of radiology, anesthesia, and pathology services to hospital inpatients.—The Health Care Financing Administration conducts a variety of studies on reimbursement, coverage, eligibility, and management alternatives under Medicare.

House bill

(a) Additional members for Physician Payment Review Commission.—

Section 10234.—Expands the membership of the Physician Payments Review Commission by 2 members to 13. The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Commission no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will ensure that (on a continuing basis) the terms of no more than five members expire in any 1 year.

Section 5431.—Similar provision.

(b) Effective date on voluntary disenrollment from Medicare.—

Section 10234.—Modifies the effective date of disenrollment from Medicare when a beneficiary files a notice to disenroll to the close of the calendar quarter in which the notice is filed.

Section 4531.—No provision.

(c) Study on prospective payment of radiology, anesthesia, and pathology services to hospital inpatients.—

Section 10234.—Requires the Secretary to study and report to the House Ways and Means Committee by April 1, 1987, concerning the implementation of a part B prospective payment system for radiology, anesthesia, and pathology services furnished to hospital inpatients. The report is required to include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

Section 4531.—No provision.

Effective date.—(a) enactment; (b) applies to notices filed on or after October 1, 1986; (c) enactment.

Senate amendment

No provision.

Conference agreement

(a) Additional members for Physician Payment Review Commission.—The conference agreement includes the House provision. The conferees intend that at least one of the members would represent a rural area.

(b) Effective date on voluntary disenrollment from Medicare.—The conference agreement includes the House provision of Section 10234 with an amendment specifying that the effective date is the first day of the second month following the month in which the beneficiary files the required notice.

(c) Study on prospective payment of radiology, anesthesia and pathology services to hospital inpatients.—The conference agreement includes the House provision of Section 10234 with an amendment to delay the reporting date of the study to July 1, 1987.

25. VISION CARE (SECTION 4521 OF HOUSE BILL)

Present law

Medicare pays for eye examinations furnished by a physician to a patient with a complaint or symptom of eye disease or injury. Medicare excludes payment for eyeglasses and eye examinations for the purposes of prescribing, fitting, or changing eyeglasses (except for prosthetic lenses for aphakic patients; that is, those without the natural lens of the eye.) Payment is also excluded for procedures performed to determine the refractive state of the eye. An optometrist who is legally authorized by the State to practice optometry is defined as a physician, but only with respect to services related to the treatment of aphakic patients.

House bill

Allows payment under Medicare for vision care services performed by optometrists, if the services are among those already covered by Medicare when furnished by a physician and if the optometrist is authorized by State law to provide the services.

Effective date.—Services furnished on or after April 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

26. OCCUPATIONAL THERAPY SERVICE (SECTION 4522 OF HOUSE BILL; SECTION 625 OF SENATE AMENDMENT)

Present law

Medically necessary occupational therapy services are covered under part A when provided as part of covered inpatient hospital services, skilled nursing facility services, home health services or hospice care. Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to physicians' services.

House bill

(a) Services furnished in skilled nursing facilities and other providers.—Extends part B coverage of occupational therapy services to services provided in skilled nursing facilities (when part A coverage has been exhausted), in a clinic, rehabilitation agency, or public health agency or by others under arrangements with such entities. Reimbursement is on the basis of reasonable costs subject to the provision that the reasonable costs of services furnished under arrangements cannot exceed the amount that would be paid on a salary related basis.

(b) Services furnished in beneficiary's home and private offices.—Extends part B coverage to occupational therapy services furnished by an independently practicing therapist in a therapist's office or a beneficiary's home. The independently practicing therapist would be required to meet licensing and other standards prescribed by the

E (SECTION 4521 OF HOUSE BILL)

examinations furnished by a physician to
nt or symptom of eye disease or injury.
ent for eyeglasses and eye examinations
scribing, fitting, or changing eyeglasses
ises for aphakic patients; that is, those
of the eye.) Payment is also excluded for
determine the refractive state of the eye.
gally authorized by the State to practice
physician, but only with respect to serv-
ent of aphakic patients.

- Medicare for vision care services per-
if the services are among those already
n furnished by a physician and if the op-
State law to provide the services.
s furnished on or after April 1, 1987.

ent includes the House provision.

APY SERVICE (SECTION 4522 OF HOUSE BILL;
25 OF SENATE AMENDMENT)

ccupational therapy services are covered
ided as part of covered inpatient hospital
facility services, home health services or
erage is limited to treatment in a hospital
omprehensive outpatient rehabilitation fa-
ncy, or when provided incident to physi-

in skilled nursing facilities and other pro-
coverage of occupational therapy services
illed nursing facilities (when part A cover-
d), in a clinic, rehabilitation agency, or
by others under arrangements with such
is on the basis of reasonable costs subject
ne reasonable costs of services furnished
not exceed the amount that would be paid

in beneficiary's home and private offices.—
to occupational therapy services furnished
cticing therapist in a therapist's office or a
independently practicing therapist would
sing and other standards prescribed by the

Secretary. Reimbursement is on the basis of 80 percent of reasonable charges, with no more than $500 in incurred expenses eligible for coverage in a calendar year. A physician must certify the need for such services and a treatment plan must be established by a physician or by the qualified occupational therapist.

Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after April 1, 1987.

Senate amendment

(a) Services furnished in skilled nursing facilities and other providers.—Identical provision.

(b) Services furnished in beneficiary's home and private offices.—Identical provision.

Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after October 1, 1986.

Conference agreement

(a) Services furnished in skilled nursing facilities and other providers.—The conference agreement includes the Senate amendment with an amendment changing the effective date to July 1, 1987.

(b) Services furnished in beneficiary's home and private office.—The conference agreement includes the Senate amendment with an amendment changing the effective date to July 1, 1987.

27. COVERAGE OF SERVICES OF A PHYSICIAN ASSISTANT (SECTION 4523 OF HOUSE BILL)

Present law

Payments are made to a physician for services and supplies furnished incident to a physician's professional services. The services of nonphysicians are covered as incident to physicians' services and such services must be rendered under the physician's direct supervision.

House bill

(a) Covered services.—Authorizes coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, or as an assistant-at-surgery. The physician assistant must be legally authorized to perform such services in the State in which the services are performed. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' services.

(b) Payment for services.—The prevailing charge for a service furnished by a physician's assistant may not exceed 90% of the prevailing charge for the same service when furnished by a physician. Payment may only be made to the employer of the physician assistant when services are provided on the basis of assignment.

Effective date.—Services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Covered services.—The conference agreement includes the House provision with an amendment to add to the definition of covered physician assistant services those services provided by a physician assistant in an intermediate care facility.

(b) Payment for services.—The conference agreement includes the House provision with a modification. Physician assistant services are subject to a prevailing charge screen equal to 85% of the prevailing charge for comparable physicians services performed by nonspecialists when such services are performed in skilled nursing facilities or intermediate care facilities. The prevailing charge screen is to be equal to 75% of the nonspecialist physicians prevailing charge level when such services are performed in a hospital and 65% of the reasonable charge for a physician when acting as an assistant at surgery. The conference agreement requires physician assistants to accept assignment for all claims and imposes civil monetary penalties for violations.

The agreement requires the Secretary to submit a report to Congress by April 1, 1988 concerning appropriate adjustments to payments for physician assistant services to ensure that payments for such services approximate the cost of furnishing such services, including compensation costs and overhead costs, and costs of physician supervision attributable to employment of physicians' assistants. The Secretary, in making recommendations to the Congress, shall consider both the advisability of adjusting current rates or developing a fee-schedule.

The Secretary is authorized to reduce Medicare payment rates to the extent necessary to avoid double payments for such services. The Secretary is expected to require carriers to conduct utilization review of claims to avoid duplication of payment for physicians and physician assistant services.

28. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS (SECTION 4528 OF HOUSE BILL)

Present law

Payment for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed either in a physician's office or by an independent laboratory (including a hospital laboratory furnishing services to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided to a hospital's outpatients.

For the period beginning July 1, 1984, the rates under both schedules were established on a regional, statewide, or carrier service area basis. The first fee schedule was set at 60 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The second fee schedule was set at 62 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The fee schedules are adjusted annually to reflect changes in the consumer price index for all urban consumers. Beginning July 1, 1986, the Secretary is required to establish payment ceilings for each test to be applied nationwide. Beginning July 1, 1988, the fee schedule for tests performed either in a physi-

'he conference agreement includes the
mendment to add to the definition of cov-
ervices those services provided by a physi-
ediate care facility.
—The conference agreement includes the
nodification. Physician assistant services
charge screen equal to 85% of the pre-
arable physicians services performed by
services are performed in skilled nursing
care facilities. The prevailing charge
% of the nonspecialist physicians prevail-
ich services are performed in a hospital
le charge for a physician when acting as
'he conference agreement requires physi-
ssignment for all claims and imposes civil
ilations.
the Secretary to submit a report to Con-
ncerning appropriate adjustments to pay-
ant services to ensure that payments for
e the cost of furnishing such services, in-
s and overhead costs, and costs of physi-
ible to employment of physicians' assist-
aking recommendations to the Congress,
visability of adjusting current rates or de-

ized to reduce Medicare payment rates to
void double payments for such services.
to require carriers to conduct utilization
duplication of payment for physicians and
es.

L DIAGNOSTIC LABORATORY TESTS (SECTION
28 OF HOUSE BILL)

oratory services are made on the basis of
ee schedule is established for laboratory
a physician's office or by an independent
ospital laboratory furnishing services to
nts of the hospital). A second schedule is
aboratory services provided to a hospital's

ing July 1, 1984, the rates under both
d on a regional, statewide, or carrier serv-
fee schedule was set at 60 percent of the
established for the fee screen year begin-
cond fee schedule was set at 62 percent of
els established for the fee screen year be-
fee schedules are adjusted annually to re-
umer price index for all urban consumers.
he Secretary is required to establish pay-
est to be applied nationwide. Beginning
dule for tests performed either in a physi-

cian's office or by an independent laboratory is to be established on a national basis. At the same time, payment for hospital laboratory services is slated to revert to cost-based reimbursement.

House bill

(a) Treatment of hospital outpatient laboratories.—Conforms fee schedule for hospital outpatient laboratories to that for independent laboratories by eliminating the 2 percent differential and by eliminating the January 1, 1988, sunset provision on the fee schedule for such laboratory services.

(b) National fee schedule.—Eliminates requirement for the national fee schedule. The Secretary is required to report to the Congress by April 1, 1988, on the advisability and feasibility of establishing a national fee schedule.

(c) Payment for travel costs.—Authorizes the Secretary to provide for and establish a fee to cover transportation and personnel expenses for trained personnel to travel to the location to collect the sample. Such fee may only by provided with respect to a beneficiary who is homebound or an inpatient in a facility other than a hospital.

(d) State standards for directors of clinical laboratories.—Specifies that clinical laboratories that meet State licensure laws regarding medical direction are qualified to receive payments under Medicare.

Effective date.—(a) applies to tests performed on or after January 1, 1987. (b) effective on enactment. (c) applies to samples collected on or after January 1, 1987. (d) effective January 1, 1987.

Senate amendment

No provision.

Conference agreement

(a) Treatment of hospital outpatient laboratories.—The conference agreement includes the House provision with an amendment. The 2 percent differential for hospital outpatient laboratories would be maintained for such laboratories if they are in a hospital which operates a 24 hour per day emergency room, and the laboratory is available to provide laboratory services for the emergency room 24 hours a day, seven days a week.

(b) National fee schedule.—The conference agreement includes the House provision with an amendment. Implementation of the national fee schedule would be postponed for two years, until January 1, 1990.

(c) Payment for travel costs.—The conference agreement includes the House provision.

(d) State standards for directors of clinical laboratories.—The conference agreement includes the House provision.

In addition, the conference agreement would extend the moratorium on the competitive bidding demonstration project until January 1, 1988. The conferees expect the Secretary to continue to work with the industry and the Comptroller General to determine whether there is an alternative method of utilizing competitive market forces in establishing payment levels under Medicare.

29. PAYMENT OF PARENTERAL AND ENTERAL NUTRITION SUPPLIES (SECTION 4529 OF HOUSE BILL)

Present law

Reasonable charges for medical services, supplies and equipment that, in the judgment of the Secretary, do not vary substantially in quality from one supplier to another may not exceed the lowest charge levels at which such services, supplies and equipment are widely and consistently available, except to the extent and under circumstances specified by the Secretary. Regulations implementing this provision established such lowest charge levels at the 25th percentile of the charges submitted for the item or service in question.

Parenteral and enteral nutrition supplies and equipment are currently paid on the basis of reasonable charges.

House bill

Requires the Secretary to apply the lowest charge level provision to parenteral and enteral nutrition supplies.

Effective date.—Applies to supplies on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification. In establishing the "lowest charge level" for parenteral and enteral supplies, the Secretary would be required to base payments at the 25th percentile as currently set forth in regulations (42 CFR 405.511(c)). The conferees expect that all available charge data submitted by suppliers of such services would be used in calculating the lowest charge levels. The Secretary and carriers would therefore be prohibited from using "inherent reasonableness" in establishing the lowest charge level.

In addition, the conferees are concerned that some items (e.g. supply and administration kits) are billed on a partial month basis which may distort the charge data. The conferees expect the Secretary to ensure that the data used in establishing the lowest charge level for these items are accurate.

In comparing charges submitted for various items, the conferees expect the Secretary to compare like products which are of comparable quality and nutritional content rather than looking solely at the volume of nutrients or calorie content. In addition, the conferees expect that the Secretary would not group together products of dissimilar quality or function.

The conferees are concerned that current categories for reimbursing premixed parenteral solutions may be inappropriate. The conferees therefore expect the Secretary to establish new categories for premixed parenteral solutions based on the amount of proteins prescribed per day. The Secretary would be expected to calculate payment levels at the 25th percentile based on the charge data available for the new categories. To provide sufficient time to collect the data, the effective date for parenteral products would be October 1, 1987.

nedical services, supplies and equipment
ie Secretary, do not vary substantially in
to another may not exceed the lowest
ch services, supplies and equipment are
vailable, except to the extent and under
the Secretary. Regulations implement-
hed such lowest charge levels at the 25th
submitted for the item or service in ques-

nutrition supplies and equipment are cur-
f reasonable charges.

to apply the lowest charge level provision
nutrition supplies.
s to supplies on or after January 1, 1987.

nent includes the House provision with a
ning the "lowest charge level" for parenter-
the Secretary would be required to base
ercentile as currently set forth in regula-
). The conferees expect that all available
by suppliers of such services would be used
t charge levels. The Secretary and carriers
ohibited from using "inherent reasonable-
e lowest charge level.
ferees are concerned that some items (e.g.
ion kits) are billed on a partial month basis
charge data. The conferees expect the Secre-
data used in establishing the lowest charge
e accurate.
s submitted for various items, the conferees
compare like products which are of compa-
itional content rather than looking solely at
ts or calorie content. In addition, the confer-
cretary would not group together products of
inction.
concerned that current categories for reim-
enteral solutions may be inappropriate. The
pect the Secretary to establish new categories
al solutions based on the amount of proteins
The Secretary would be expected to calculate
e 25th percentile based on the charge data
categories. To provide sufficient time to col-
ective date for parenteral products would be

Between January 1, 1987 and October 1, 1987, the Secretary is to apply existing charge screens to these parenteral nutrients. However, rather than applying many different screens to the various states, the Secretary should apply uniform screens throughout the nation, or uniform screens throughout each of the two carrier areas.

It is the conferees' understanding that certain parenteral nutritional patients require special parenteral solutions such as renal failure solutions, hepatic failure solutions, or acute metabolic stress formulas. The Secretary would be expected to provide for separate categorization or appropriate exceptions to accommodate these patients and for other special circumstances.

The provision would be effective for parenteral nutrients October 1, 1987, and for all other services and supplies on January 1, 1987.

30. PAYMENT FOR OXYGEN THERAPY SERVICES (SECTION 4530 OF HOUSE BILL)

Present law

Oxygen therapy services provided in the home are reimbursed on a reasonable charge basis under part B of Medicare.

Payments for equipment are determined separately from payments for consumable oxygen. Total payments for consumable oxygen are determined by the amount of oxygen actually supplied.

House bill

Requires the Secretary to establish monthly capitation fee schedules on a regional, statewide, or carrier service area basis for oxygen therapy services under part B. Payment shall be made on the basis of the number of units of oxygen prescribed by physicians, subject to verification by laboratory data or other means deemed appropriate by the Secretary.

No payment may be made for services prescribed by a physician if the physician has significant ownership or financial interest in the entity supplying the oxygen therapy services, except with respect to sole suppliers as determined by the Secretary.

The Secretary will provide for prompt payment of claims for oxygen therapy services (clean claims to be paid within 22 calendar days), or the carrier will pay interest on the amount payable. The carriers are to be reimbursed for their interest expense from amounts made available for Federal administrative expenses under part B.

The Secretary shall establish the monthly capitation fee schedules based on 100 percent of the reasonable charge level for oxygen therapy services (excluding purchase or rental of equipment) for such services furnished in the region, State, or area for the 12 month period ending June 30, 1986. The fee schedules are to be adjusted annually, effective January 1 (beginning in 1987), by the percentage change in the Consumer Price Index for All Urban Consumers, subject to adjustments for technological changes and other factors as determined by the Secretary.

The Secretary shall provide for a percentage increase in the fee schedule amounts for oxygen therapy services provided through a portable device. The Secretary shall also provide for a minimum

monthly amount to assure the availability of such therapy for individuals consuming small amounts of oxygen.

Program payment amounts are to be 80 percent of the amount determined under the monthly prospective fee schedule. In general, payment would only be made on the basis of assignment.

Effective date.—Applies to oxygen therapy services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

31. CHANGING MEDICARE APPEAL RIGHTS (SECTION 4532 OF HOUSE BILL)

Present law

Beneficiaries dissatisfied with a carrier's disposition of a part B claim are entitled to a review by the carrier. A fair hearing by the carrier is then available if the amount in controversy is $100 or more. The law does not provide for any further administrative appeal or judicial review for a part B claim.

House bill

Provides that beneficiaries may obtain an administrative law judge hearing if the amount in controversy is $500 or more and judicial review if the amount in controversy is $1,000 or more. In determining the amount in controversy, the Secretary under regulations must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals. Carrier hearings are retained for amounts in controversy between $100 and $500.

Specifies that national coverage determinations made pursuant to section 1862(a)(1) of the Act are not subject to review by an administrative law judge but are subject to judicial review.

Effective date.— Applies to items and services furnished on or after January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with amendments regarding the scope of judicial review and the form of relief that a court may order.

Coverage determinations of national applicability could not be overturned solely on the grounds that they were not issued in accordance with the notice and comment procedures in the Administrative Procedure Act, as amended. The process used by the Secretary in making such determinations, including the role of the National Center for Health Services Research and Health Care Technology Assessment, is designed to assure consultation with the sci-

the availability of such therapy for indi-
nounts of oxygen.
nts are to be 80 percent of the amount
thly prospective fee schedule. In general,
de on the basis of assignment.
to oxygen therapy services furnished on

ent does not include the House provision.

APPEAL RIGHTS (SECTION 4532 OF HOUSE BILL)

d with a carrier's disposition of a part B
view by the carrier. A fair hearing by the
if the amount in controversy is $100 or
provide for any further administrative
for a part B claim.

aries may obtain an administrative law
unt in controversy is $500 or more and ju-
nt in controversy is $1,000 or more. In de-
controversy, the Secretary under regula-
more claims to be aggregated if the claims
imilar or related services to the same indi-
on issues of law and fact arising from serv-
more individuals. Carrier hearings are re-
ntroversy between $100 and $500.
l coverage determinations made pursuant
he Act are not subject to review by an ad-
out are subject to judicial review.
lies to items and services furnished on or

ement includes the House provision with
the scope of judicial review and the form of
order.
tions of national applicability could not be
he grounds that they were not issued in ac-
ce and comment procedures in the Adminis-
as amended. The process used by the Secre-
leterminations, including the role of the Na-
th Services Research and Health Care Tech-
designed to assure consultation with the sci-

entific and medical community and the general public. If that process is adhered to, the further procedure of publishing proposed and final regulations in the Federal Register does not seem essential.

The court could, however, review coverage determinations to determine whether the Secretary arrived at the result in a arbitrary manner or without an adequate basis. If the court invalidated a coverage determination on this basis, it would not substitute a revised coverage determination but, instead, would provide the Secretary a reasonable opportunity to supplement the record and substantiate or revise the coverage determination. If the court, on review of the supplemented record, concluded that the Secretary had still failed to substantiate the determination, the court could then enter an appropriate order.

The amendment also limits the judiciary in reviewing payment methodologies established by the Secretary. Methodologies established by regulation or policy instruction could not be declared invalid if the regulation was promulgated or the instruction issued prior to January 1, 1981. Policies would otherwise be reviewable.

32. ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS (SECTION 4533 OF HOUSE BILL)

Present law

Medicare beneficiaries with Alzheimer's disease or related disorders are covered for acute medical care services they might need. However, many of the home and community-based services which these persons require in order to remain in their homes are not covered by Medicare.

House bill

Requires the Secretary of HHS to conduct at least 5 demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders. Services provided under the demonstration projects must be designed to meet the specific needs of Alzhemier's disease patients and may include case management, home and community-based services, mental health services, outpatient drug therapy, respite care and other supportive services and counseling for family, adult day care services and other inhome services. Each demonstration project would be conducted over a period of 3 years and at sites chosen so as to be geographically diverse and located in States with a high proportion of Medicare beneficiaries and in areas readily accessible to a significant number of Medicare beneficiaries.

Requires that projects provide each Medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge. Also requires that projects be conducted by entities which either directly or by contract are able to provide these evaluations and additional services covered. Projects also would be required to involve community outreach efforts at each site to enroll the maximum number of Medicare beneficiaries in each project.

64-554 O - 86 - 12

Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period he finds necessary for the projects.

Requires the Secretary to provide for an evaluation of the projects and to submit to Congress two reports: a preliminary report during the third year of the projects and a final report upon completion that includes recommendations for appropriate legislative changes.

Specifies that expenditures not exceed $40 million for the projects and $2 million for the evaluation and be made from the Federal Supplementary Medical Insurance Trust Fund.

Effective date.—Enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with an amendment permitting the Secretary to conduct additional demonstration projects, up to a total of 10, within the appropriation of $40 million over 3 years. The Secretary could undertake the additional projects by reducing the number of beneficiaries participating in these demonstrations from 500 to approximately 250.

The conferees intend the services covered under this demonstration to supplement current Medicare acute care benefits. These additional benefits are not to replace, reduce, restrict, or otherwise substitute for existing benefits provided through Medicare which the beneficiaries might need. These demonstration projects are to be funded from the Medicare Part B trust fund, without being charged against the monies appropriated for the research activities of the Health Care Financing Administration.

In addition, the conference agreement includes a modification to the preventive health services demonstration program as added by COBRA. The agreement would clarify that the $4 million funding limitation specified in COBRA applies only to the administrative cost of designing and conducting the demonstration and the accompanying evaluation. The funding limitation would be increased by $1.9 million.

The provision would also specify that at least one of the five sites chosen for the demonstration must serve a rural area.

33. AMBULATORY SURGERY (SECTION 624 OF SENATE AMENDMENT)

Present law

Payment for facility services.—Medicare may pay for ambulatory surgical procedures performed in three different settings:

Ambulatory surgical center (ASC).—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary. Payments to ASCs are made on the basis of prospectively set rates known as the "standard overhead amount." On August 5, 1982, HHS issued final regulations and an accompanying notice identifying four groups of surgical procedures and the payment amount for

to waive compliance with Medicare re-
and for the period he finds necessary for

to provide for an evaluation of the
o Congress two reports: a preliminary
ar of the projects and a final report upon
ecommendations for appropriate legisla-

tures not exceed $40 million for the
or the evaluation and be made from the
edical Insurance Trust Fund.
ent.

ent includes the House provision with an
ie Secretary to conduct additional demon-
total of 10, within the appropriation of
The Secretary could undertake the addi-
ig the number of beneficiaries participat-
ns from 500 to approximately 250.
ie services covered under this demonstra-
it Medicare acute care benefits. These ad-
to replace, reduce, restrict, or otherwise
enefits provided through Medicare which
ieed. These demonstration projects are to
dicare Part B trust fund, without being
ies appropriated for the research activities
cing Administration.
ence agreement includes a modification to
rvices demonstration program as added by
would clarify that the $4 million funding
OBRA applies only to the administrative
iducting the demonstration and the accom-
funding limitation would be increased by

lso specify that at least one of the five sites
ation must serve a rural area.

ERY (SECTION 624 OF SENATE AMENDMENT)

ervices.—Medicare may pay for ambulatory
ormed in three different settings:
cal center (ASC).—The Omnibus Reconcilia-
L. 96–499) authorized payments for facility
n connection with ambulatory surgical pro-
by the Secretary. Payments to ASCs are
of prospectively set rates known as the
l amount." On August 5, 1982, HHS issued
nd an accompanying notice identifying four
procedures and the payment amount for

each group. The payment amounts and the list of procedures has not been updated. The rates do not include payments for physicians' services, prosthetic devices, or laboratory services. No beneficiary cost-sharing is required.

Hospital outpatient department.—Medicare payments for ambulatory surgery performed in a hospital outpatient department are made on the basis of reasonable costs. The standard Part B beneficiary cost-sharing is required.

Physician's office.—P.L. 96–499 also authorized payments to be made to physicians for the use of their office facilities when covered ambulatory surgical procedures were performed there. However, the legislation has not been implemented because adequate utilization and quality control peer review, which is required by law, is not available for office-based surgery.

Payment for physicians' services.—When surgery is performed in any of these three settings, Medicare reimburses 100 percent of the physician's reasonable charge, provided the physician agrees to accept assignment.

House bill

No provision.

Senate amendment

(a) Payment rates.—Provides that payments to hospital outpatient departments for procedures approved for ASCs, would be the lesser of the outpatient department's cost or the payment rate for the same surgical procedure in an ASC in the same geographic area.

When the payment rate is based on the ASC payment rate, the outpatient department would receive additional payments for the cost of the services of certified nurse anesthetists (for cost reporting periods beginning before October 1, 1987) and for the direct costs of medical education.

The Secretary is required to review and update the ASC payment rates not later than July 1, 1987, and annually thereafter, and to review and update the list of approved procedures not less than annually.

(b) Facility services definition.—Specifies that "facility services" for which payment is made includes all "medical and other health services" furnished in connection with the procedure except the services of physicians.

(c) PRO review.—Requires Peer Review Organization contracts to provide for review of all ambulatory surgical procedures (or, at the Secretary's discretion, a sample of selected procedures) performed in ASCs and hospital outpatient departments.

(d) Coinsurance and deductible to apply without regard to setting of ambulatory surgery.—Repeals current law provisions waiving coinsurance and deductible requirements for ASC services.

(e) Development of prospective payment methodology for outpatient hospital services.—Requires the Secretary to develop groupings of pre- and postoperative services that are related to surgical services performed in a hospital outpatient department and then develop a model prospective reimbursement system that may be used for reimbursing hospitals under part B. The Secretary is re-

quired to report to Congress on the groupings and the model reimbursement system not later than January 1, 1991.

(f) Study of educational activities.—Requires the Secretary to conduct a study on educational activities in hospital outpatient departments. The Secretary shall report the results to Congress not later than 2 years after enactment.

Effective date.—The payment provisions in (a) apply to cost reporting periods beginning on or after July 1, 1987. (b) and (d) apply to services furnished after June 30, 1987. (c) applies to contracts entered into or renewed after January 1, 1987. All other provisions are effective on enactment.

Conference agreement

(a) Payment rates.—The conference agreement includes the Senate amendment with modification. The conferees anticipate that the payment mechanism established under this section will be a transitional step, and the conference agreement requires the development and implementation of a fully prospective payment system for ambulatory surgery procedures provided in hospital outpatient departments (OPDs) by October 1, 1989.

Under the conference agreement, a new payment methodology for facility services provided by hospital OPDs in connection with ambulatory surgery would be established effective for hospital cost reporting periods beginning on or after October 1, 1987. Payments would be based on a comparison between the amount that would be paid to a hospital OPD under Section 1833(a)(2)(B) and a blended amount based on the amount that would be paid to an OPD under Section 1833(a)(2)(B) and the payment that would be made to a free-standing ambulatory surgery center (ASC) under Section 1833(i)(2)(A) (as amended by paragraph d). Under Section 1833(a)(2)(B), services provided by an OPD are paid at the lesser of the reasonable cost for the service or the hospital's customary charge for the service, less 20% of the hospital's reasonable charge, as provided under Section 1866(a)(2)(ii), not to exceed 80% of reasonable cost. Under Section 1833(i)(2)(A), ASCs are paid 80% of a "standard overhead amount" which is intended to reflect costs incurred by ASCs.

During a cost reporting period, aggregate payment to a hospital outpatient department (OPD) for facility services for ambulatory surgery procedures would be the lesser of: (i) the aggregate amount that would be paid to an OPD under Section 1833(a)(2)(B) of the Social Security Act of (ii) an aggregate amount based on a blend of the OPD payment under Section 1833(a)(2)(B) and the ASC payment under Section 1933(i)(2)(A). For cost reporting years beginning during FY 1988, the blend is 75% OPD payment and 25% ASC rate. For cost reporting years beginning during FY 1989 (and in subsequent years), the blend is 50% OPD payment and 50% ASC rate.

Medical and other health services, other than facility services, which are provided by a hospital OPD in connection with an ambulatory surgery procedure which are otherwise covered under medicare would continue to be reimbursed on the basis of Section 1833(a)(2)(B). While the Secretary will have flexibility in defining the term "facility services" for purposes of this provision, it is an-

ngress on the groupings and the model reim-
later than January 1, 1991.
tional activities.—Requires the Secretary to
ucational activities in hospital outpatient de-
.ary shall report the results to Congress not
r enactment.
payment provisions in (a) apply to cost re-
ing on or after July 1, 1987. (b) and (d) apply
fter June 30, 1987. (c) applies to contracts en-
after January 1, 1987. All other provisions
nent.

—The conference agreement includes the
vith modification. The conferees anticipate
hanism established under this section will be
d the conference agreement requires the de-
·mentation of a fully prospective payment
surgery procedures provided in hospital out-
)PDs) by October 1, 1989.
ce agreement, a new payment methodology
ovided by hospital OPDs in connection with
ould be established effective for hospital cost
nning on or after October 1, 1987. Payments
)mparison between the amount that would be
D under Section 1833(a)(2)(B) and a blended
amount that would be paid to an OPD under
)d the payment that would be made to a free-
surgery center (ASC) under Section
:nded by paragraph d). Under Section
)rovided by an OPD are paid at the lesser of
'or the service or the hospital's customary
less 20% of the hospital's reasonable charge,
:tion 1866(a)(2)(ii), not to exceed 80% of rea-
:ection 1833(i)(2)(A), ASCs are paid 80% of a
mount" which is intended to reflect costs in-

ting period, aggregate payment to a hospital
t (OPD) for facility services for ambulatory
)uld be the lesser of: (i) the aggregate amount
) an OPD under Section 1833(a)(2)(B) of the
(ii) an aggregate amount based on a blend of
)der Section 1833(a)(2)(B) and the ASC pay-
)33(i)(2)(A). For cost reporting years beginning
blend is 75% OPD payment and 25% ASC
ng years beginning during FY 1989 (and in
: blend is 50% OPD payment and 50% ASC

health services, other than facility services,
a hospital OPD in connection with an ambu-
)re which are otherwise covered under medi-
to be reimbursed on the basis of Section
)e Secretary will have flexibility in defining
)vices" for purposes of this provision, it is an-

ticipated that the term will be defined in a manner that is comparable to the definition of the term "ASC facility service" that appears at 42 CFR 416.61.

The conference agreement does not include the Senate amendment concerning nurse anesthetist and direct medical education costs because, under the conference agreement, these provisions are not needed to ensure payment of these costs. The services of a nurse anesthetist are not included in the current definition of "ASC facility services," and it is anticipated that such services would not be included within the term "facility services" for purposes of paying hospital OPDs. Accordingly, no "pass-through" is required for the costs of hospital-employed nurse anesthetists, and these costs will continue to be reimbursed on a reasonable cost basis. In addition, no "pass-through" is required for direct medical education costs because of the payment methodology established for these costs under Section 1886(h) of the Social Security Act.

(b) Facility service definition.—The conference agreement does not include the Senate amendment, but does require that all services (other than physician services) provided by an OPD be billed through the hospital. Separate billing for such items or services by other suppliers would be prohibited and violations would be subject to civil monetary penalties.

(c) PRO review.—The conference agreement includes the Senate amendment with technical clarifications regarding the requirement that PROs review some or all of the ambulatory surgery services provided by hospital OPDs and ASCs. Under the agreement, the Secretary would have discretion to review a sample of such procedures.

(d) Coinsurance and deductible to apply without regard to setting of ambulatory surgery.—The conference agreement includes the Senate amendment.

(e) Development of prospective payment methodology for outpatient hospital services.—The conference agreement includes the Senate amendment with the following modifications. The Secretary would be required to submit an interim report to Congress by April 1, 1988 concerning development of a fully prospective payment system for ambulatory surgery. The following issues are to be addressed in the interim report: (i) whether payment for hospitals should be based on hospital costs in providing ambulatory services, or the ASC payment rate, or a blend of the two; and (ii) recommendations for developing and implementing an all-inclusive payment for ambulatory surgery encompassing payment for facility services and all medical and other health services commonly furnished in connection with an ambulatory surgical procedure other than the physicians' service. The Secretary would be required to submit a final report to Congress no later than April 1, 1989 with recommendations concerning implementation of a fully prospective payment mechanism for ambulatory surgery services by October 1, 1989. The Secretary would also be required to develop a model system for prospective payment of OPD services other than ambulatory surgical procedures and submit a report to Congress concerning the model system by January 1, 1991.

(f) Study of educational activities.—The conference agreement does not include the Senate amendment.

III. Utilization and Quality Control Peer Review Organization (PRO) Provisions

1. Peer review organizations (section 10241 of House bill; sections 631, 632, and 633 of Senate amendment)

Present law

(a) PRO Review of Hospital Denial Notices.—By regulation, hospitals are authorized to make determinations that further inpatient care is no longer medically necessary. If the attending physician concurs with this determination, the hospital may serve the beneficiary with a discharge notice and may begin to charge for continued stay beginning with the third day after serving the notice. The beneficiary may appeal the discharge notice to a peer review organization (PRO). If the PRO reverses the hospital's determination, the hospital may not bill for continued inpatient stay. The PRO is required to decide the appeal within 3 working days after receipt of the appeal. Under current policy, a beneficiary may incur financial liability for several days of continued stay before receiving notice of the PROs decision in the event of an adverse decision.

(b) PRO Review of Inpatient Hospital Services and Early Readmission Cases.—PROs review the necessity and quality of hospital services provided to beneficiaries.

(i) To initiate the review process, a PRO must receive data concerning the number and type of hospital discharges from hospitals in the PROs services area. This information is provided to PROs by Medicare fiscal intermediaries. There is no statutory provision regarding timely provision of data to PROs.

(ii) Under PRO contracts for 1986–88, PROs will be required to review all readmissions to a hospital where the readmission occurs within 15 days after initial discharge.

(c) Requiring PRO Review of Quality of Care.—PROs are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and meet professionally recognized standards of care. COBRA required PROs to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs) effective January 1, 1987. A required level of effort for PRO review of HMO and CMP services is not specified.

(d) Requiring consumer representation on PRO boards.—No Provision.

(e) Improve peer review responsiveness to beneficiary complaints.—No provision.

(f) Sharing of information by PROs.—PRO confidential information is subject to protection.

(g) Funding of PRO activities.—The costs of PRO review are funded by transfer of funds from the Federal Hospital Insurance Trust Fund. Under current law, the aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during FY 1986 on PRO reviews adjusted for inflation.

ND QUALITY CONTROL PEER REVIEW
IZATION (PRO) PROVISIONS

NIZATIONS (SECTION 10241 OF HOUSE BILL; 2, AND 633 OF SENATE AMENDMENT)

spital Denial Notices.—By regulation, hos- make determinations that further inpa- nedically necessary. If the attending physi- determination, the hospital may serve the harge notice and may begin to charge for ng with the third day after serving the may appeal the discharge notice to a peer O). If the PRO reverses the hospital's deter- may not bill for continued inpatient stay. o decide the appeal within 3 working days eal. Under current policy, a beneficiary may for several days of continued stay before re- tOs decision in the event of an adverse deci-

npatient Hospital Services and Early Read- review the necessity and quality of hospital neficiaries.

review process, a PRO must receive data mber and type of hospital discharges from tOs services area. This information is provid- dicare fiscal intermediaries. There is no stat- garding timely provision of data to PROs. ontracts for 1986–88, PROs will be required missions to a hospital where the readmission ays after initial discharge.

eview of Quality of Care.—PROs are required the professional activities of health care prac- rs for purposes of determining whether the medically necessary and meet professionally of care. COBRA required PROs to review ealth maintenance organizations (HMOs) and lans (CMPs) effective January 1, 1987. A re- for PRO review of HMO and CMP services is

mer representation on PRO boards.—No Provi-

iew responsiveness to beneficiary complaints.—

mation by PROs.—PRO confidential informa- ection.

tO activities.—The costs of PRO review are f funds from the Federal Hospital Insurance rrent law, the aggregate amount to be paid to ar must be no less than the aggregate amount 1986 on PRO reviews adjusted for inflation.

House bill

(a) PRO review of hospital denial notices.—

(i) Provides that if a hospital determines and the physician agrees that the patient no longer requires inpatient care, the hospital may provide that patient with a coverage denial notice.

(ii) Provides that if a hospital has determined but the physician does not agree that the patient no longer requires inpatient care, the hospital may request the PRO to review the validity of the hospital's determination.

(iii) Provides that if a patient has received a denial notice and requests the PRO to review the determination, the PRO shall conduct a review of the validity of the hospital's determination and shall provide notice to the patient, hospital, and attending physician. Such review is to be provided regardless of whether or not the hospital will charge for continued care or whether or not the patient will be liable for payment for continued care.

(iv) Provides that if the patient requests a review while still an inpatient and not later than noon of the first working day after receipt of the hospital denial notice, the hospital must provide the PRO with the records required to review the determination by the close of business of such day, and the PRO must provide notice by not later than one full working day after it has received the request and the records.

(v) Provides that if the patient has made a timely request, and the patient did not know and could not reasonably have been expected to know that continued inpatient stay was not necessary, the hospital may not charge the patient before noon of the day after receipt of the PRO's decision.

(vi) Requires PRO's in conducting reviews to solicit the views of the patient.

(b) PRO review of inpatient hospital services and early readmission cases.—

(i) Requires the Secretary to provide that PROs receive each month either from hospitals or through fiscal intermediaries, data necessary to initiate the review process on a timely basis.

(ii) Requires PROs to perform early readmission reviews to determine if the previous inpatient hospital services and post-hospital services met professionally recognized standards of health care. The reviews may be done on a sample basis if the PRO and Secretary determine it to be appropriate. Any early readmission case is defined as one where a readmission occurs within 31 days of discharge.

(c) Requiring PRO review of quality of care.—

(i) Requires each PRO to provide that a reasonable proportion of its activities are involved with reviewing the quality of services and that a reasonable allocation of such activities is made the different cases and settings (including inpatient hospital care, post-acute care settings, ambulatory settings, health maintenance organizations, and competitive medical plans). In establishing the allocation, the PRO shall consider: (1) whether there is reason to believe that there is need for review of par-

ticular cases or settings because of previous problems; (2) the cost and potential yield from reviews; and (3) the availability and adequacy of alternative quality review and assurance mechanisms.

(ii) Requires each PRO contract to provide for review of inpatient and outpatient services provided by HMOs and CMPs to determine whether the quality of services meets professionally recognized standards of health care, including whether appropriate health services have not been provided or have been provided in inappropriate settings. The level of effort expended by PROs under the requirement shall be equivalent on a per beneficiary basis, to that expended on utilization and quality reviews with respect to Medicare beneficiaries not enrolled in an HMO or CMP.

(iii) Requires the Secretary, in consultation with appropriate experts, to identify methods that would be available to assist PROs in identifying those cases which are more likely than others to be associated with substandard quality.

(d) Requiring consumer representation on PRO boards.—Requires at least one consumer representative on PRO boards.

(e) Improve peer review responsiveness to beneficiary complaints.—

(i) Requires PRO's to conduct appropriate reviews of all written complaints by beneficiaries about the quality of services not meeting professionally recognized standards. The PRO is required to inform the beneficiary of its conclusions and final disposition.

(ii) Before the PRO concludes that the quality of care is substandard, it must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

(f) Sharing of information by PROs.—

(i) Provides that confidential information, relating to a specific case or possible pattern of substandard care, obtained by PROs could be shared, upon request, with a State licensing or certification agency or with a national accreditation body, but only to the extent that such information is required by such agency or body to carry out official functions.

(ii) Provides that confidential information obtained by PROs could be shared with State ombudsmen and State protection and advocacy officials, but only to the extent that such information is related to the quality of services furnished and only if the PRO determines that the information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of health care. Further the information must be needed in connection with official duties.

(g) Funding of additional PRO activities.—Requires hospitals, skilled nursing facilities and home health agencies to maintain an agreement with the appropriate PRO with respect to review of services provided by hospitals, skilled nursing facilities or home health agencies (other than inpatient hospital services) and with respect to review of beneficiary complaints regarding quality. The activities are to be considered a cost of providing services and are to be paid directly by the Secretary to the PRO. Payments are to

igs because of previous problems; (2) the
eld from reviews; and (3) the availability
ernative quality review and assurance

RO contract to provide for review of inpa-
services provided by HMOs and CMPs to
ne quality of services meets professionally
of health care, including whether appro-
s have not been provided or have been
riate settings. The level of effort expended
requirement shall be equivalent on a per
that expended on utilization and quality
to Medicare beneficiaries not enrolled in

ecretary, in consultation with appropriate
nethods that would be available to assist
those cases which are more likely than
d with substandard quality.
representation on PRO boards.—Requires
presentative on PRO boards.
responsiveness to beneficiary complaints.—
to conduct appropriate reviews of all writ-
eneficiaries about the quality of services
onally recognized standards. The PRO is
he beneficiary of its conclusions and final

) concludes that the quality of care is sub-
ovide the practitioner or person concerned
e and opportunity for discussion.
ion by PROs.—
onfidential information, relating to a spe-
pattern of substandard care, obtained by
ed, upon request, with a State licensing or
or with a national accreditation body, but
hat such information is required by such
rry out official functions.
onfidential information obtained by PROs
h State ombudsmen and State protection
ls, but only to the extent that such infor-
the quality of services furnished and only
es that the information may reflect a fail-
number of cases or a gross and flagrant
re instances to provide services of a quality
ssionally recognized standards of health
nformation must be needed in connection

onal PRO activities.—Requires hospitals,
and home health agencies to maintain an
propriate PRO with respect to review of
spitals, skilled nursing facilities or home
han inpatient hospital services) and with
eficiary complaints regarding quality. The
idered a cost of providing services and are
he Secretary to the PRO. Payments are to

be transferred in appropriate amounts from the part A and part B trust funds and shall not be less in the aggregate than the amount determined by the Secretary to be sufficient to cover the costs of specified review activities. Similar provisions apply with respect to HMOs and CMPs.

Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after enactment except that (a)(v) effective on enactment. (b)(i) Requires the Secretary to implement amendment not later than 6 months after the date of enactment. (b)(ii) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(i) and (c)(ii) apply to contracts as of January 1, 1987 except that provision requiring equivalent PRO effort for HMOs and CMPs applies to review activities conducted on or after January 1, 1988. (c)(iii) Effective on enactment. (d) Applies to contracts entered into or renewed on or after January 1, 1987. (e) Applies to complaints received on or after the first day of the first month that begins more than 9 months after the date of enactment. (f) Applies to requests for data and information made on and after the end of the sixth month period beginning on the date of enactment. (g) Amendments apply to provider agreements as of October 1, 1987 and risk-sharing contracts with HMOs and CMPs as of January 1, 1987.

Senate amendment

(a) PRO review of hospital denial notices.—
(i) Identical provision.
(ii) Identical provision.
(iii) Similar provision. Specifies that the provision applies to requests made by a person who is still an inpatient. The PRO notice must be given to the patient within two calendar days after receipt of request. No PRO notice to hospital or attending physician is required.
(iv) No provision.
(v) Provides that if an inpatient makes a request for PRO review within 1 day after the date he or she receives the denial notice, the hospital may not charge the patient for services furnished before the fourth day after receipt of the denial notice.
(vi) Identical provision.

(b) PRO review of inpatient hospital services and early readmission cases.—
(i) Requires the Secretary to provide that fiscal intermediaries are to furnish the necessary data. If the Secretary determines that a fiscal intermediary is unable to furnish the information on a timely basis, he may require the hospital to do so.
(ii) Identical provision.

(c) Requiring PRO review of quality of care.—
(i) Similar provision respecting allocation of activities except specifies that the allocation among cases and settings is to be based on instances where potential problems of quality have been identified. Does not include provision relating to items the PRO must consider.
(ii) No provision.
(iii) Identical provision.

(d) Requiring consumer representation on PRO boards.—No provision.

(e) Improve Peer Review Responsiveness to beneficiary complaints.—

(i) Similar provision. Specifies that the complaint and the name of the complainant shall be treated as confidential. The PRO is required to inform the individual that the organization has received the complaint and will take appropriate action.

(ii) No provision.

(f) Sharing of information by PROs.—

(i) Similar provision. Specifies information is related to a specific provider or practitioner. Provides that information can only be shared to the extent: (1) it relates to the quality of care provided; (2) the PRO determines it may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services meeting professionally recognized standards of health care; and (3) it is needed by the body in carrying out official duties.

(ii) No provision.

(g) Funding of additional PRO activities.—No provision.

Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on and after the first day of the first month that begins more than 30 days after enactment. (b)(i) Requires the Secretary to implement the amendment not later than six months after enactment. (b)(ii) Applies to contracts entered into or renewed after January 1, 1987. (c)(i) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(iii) Effective on enactment. (e) Applies to complaints received on or after the first day of the first month that begins at least 9 months after the date of enactment. (f) Applies to data and information requests made on and after the end of the six-month period beginning on the date of enactment.

Conference agreement

(a) PRO review of hospital denial notices.—The conference agreement includes the House provision.

(b) PRO review of inpatient hospital services and early readmission cases.—The conference agreement includes the Senate amendment with a modification excluding review of services provided by physicians in an office setting from the scope of review for early readmission cases until January 1, 1989.

(c) Requiring PRO review of quality of care.—The conference agreement includes the House provision with the following amendments. The requirement that PROs allocate a reasonable proportion of their review activities to reviewing different cases and settings would be delayed for two years as it pertains to review of services provided by physicians in an office setting.

The requirement of PRO review of HMOs and CMPs is amended by delaying the deadline for initiation of PRO review of HMOs and CMPs from January 1, 1987 as provided in the House bill to April 1 of that year. In at least 25 states the Secretary must contract for review of HMO and CMP services with the organization which has a contract to conduct review of inpatient and outpatient services pursuant to Section 1154 of the Social Security Act. The Secretary has the authority under the provision to competitively bid the con-

representation on PRO boards.—No provi-

iew Responsiveness to beneficiary com-

on. Specifies that the complaint and the inant shall be treated as confidential. The nform the individual that the organization plaint and will take appropriate action.

tion by PROs.—
on. Specifies information is related to a spe-actitioner. Provides that information can e extent: (1) it relates to the quality of care O determines it may reflect a failure in a of cases or a gross and flagrant failure in es to provide services meeting professional-ards of health care; and (3) it is needed by out official duties.

nal PRO activities.—No provision.
plies to denial notices furnished by hospitals after the first day of the first month that s after enactment. (b)(i) Requires the Secre-amendment not later than six months after s to contracts entered into or renewed after pplies to contracts entered into or renewed 1987. (c)(iii) Effective on enactment. (e) Ap-eived on or after the first day of the first ast 9 months after the date of enactment. (f) formation requests made on and after the eriod beginning on the date of enactment.

spital denial notices.—The conference agree-se provision.
patient hospital services and early readmis-ence agreement includes the Senate amend-ion excluding review of services provided by setting from the scope of review for early January 1, 1989.
review of quality of care.—The conference e House provision with the following amend-nt that PROs allocate a reasonable propor-tivities to reviewing different cases and set-d for two years as it pertains to review of hysicians in an office setting.
PRO review of HMOs and CMPs is amended ne for initiation of PRO review of HMOs and 1987 as provided in the House bill to April 1 st 25 states the Secretary must contract for MP services with the organization which has review of inpatient and outpatient services 154 of the Social Security Act. The Secretary er the provision to competitively bid the con-

tract for quality review of HOM and CMP services in the remaining twenty-five states on a state-by-state basis. No more than 50% of the total number of medicare beneficiaries enrolled in HOMs or CMPs, as of the date of the competition, can be included in the twenty-five states which are subject to competitive bidding. To qualify for the competitively bid contracts, quality review organizations must satisfy the requirements of Sections 1152 and 1153(b)(3) of the Act.

The Secretary would be required to provide data (and associated data processing support) to at least 12 PROs to enable each PRO to review and analyze small area variations in the utilization of hospital and other health services within the PROs service area. The PROs would use the small area variation information in establishing priorities for review activities and in conducting educational programs for community physicians.

(d) Requiring consumer representation on PRO boards.—The conference agreement includes the House provision.

(e) Improve peer review responsiveness to beneficiary complaints.—The conference agreement includes the Senate amendment with the following modifications. If the PRO makes a final determination with respect to whether the services which are the subject of a complaint did or did not meet professionally recognized standards of care, the PRO would be required to inform the beneficiary involved (or the beneficiary's representative) of any final action taken. Before the PRO concludes that the services involved did not meet professionally recognized standards of care, the PRO would be required to provide the practitioner (or other person concerned) with reasonable notice and opportunity for discussion.

(f) Sharing of information by PROs.—The conference agreement includes the House provision with respect to sharing of information with State licensing and certification agencies and with national accreditation bodies. The agreement does not include the House provision with respect to sharing of information with State ombudsmen and State protection and advocacy officials. The conferees emphasize the responsibility of PROs to protect the confidentiality of patient information.

(g) Funding of PRO activities.—The conference agreement includes the House provision.

VI. Access to Health Insurance Coverage Provisions

1. Incentives for the establishment of state health insurance pools (section 10251 of house bill)

Present law

States are not required to establish health insurance pools for the purpose of offering health insurance to people that are otherwise unable to purchase health insurance. However, 10 States have enacted laws establishing comprehensive health insurance associations. These associations are independent nonprofit corporations governed by a board and administered by an insurance carrier selected by the board.

The 10 States base employer participation in such pools on whether the employer maintains a health insurance plan, rather

than requiring all employers to participate whether or not they maintain a health insurance plan. Accordingly, only health insurance carriers who provide health insurance plans governed by State law are required to participate in such pools. Because the Employment Retirement Income Security Act (ERISA) preempts State law, employer-based, self-funded health plans have been exempted from any State mandate to participate in such pools.

The existing State pools are financed primarily by beneficiary premiums. To the extent that the premium revenues are insufficient, the losses of the pool are shared among the health insurance carriers underwriting health insurance in the State. However, ERISA preempts State laws relating to employee benefit plans, except for laws relating to the regulation of insurance. Self-funded employer-based plans have been found to be exempt from State laws under the ERISA preemption. Accordingly, the self-funded plans do not share in the losses of the existing pools.

House bill

(a) General rule.—Amends Chapter 41 of the Internal Revenue Code of 1954 to provide for a tax on the wages paid by large employers that are not members of qualified State health insurance pools and that employ individuals to perform services in a State that has established such a pool. The tax is equal to 5 percent of the wages paid by the employer during the taxable year for services performed in the State by the employees.

(b) Large employer defined.—A large employer is defined as an employer who, on each of some 20 days (each day being in different calendar weeks), employed 20 or more individuals for some portion of the day. The term does not include the United States, any State or political subdivision, any possession of the United States, or any agency or instrumentality of any of the foregoing (including the Postal Service and Postal Rate Commission), except that the term shall include any nonappropriated fund instrumentality of the United States.

(c) Exception for certain churches and associated organizations.—Exempts church organizations from participation in the State health insurance pools which fund procedures that are contrary to their religious tenets.

(d) Qualified health insurance pool defined.—A qualified health insurance pool is defined as any organization which: (1) is a nonprofit organization established pursuant to and regulated by State law; (2) permits any large employer doing business in the State to be a participating member; and (3) makes available (without regard to health status) to all residents of the State not entitled to Medicare, levels of health insurance typical of large employer group coverage. Any such level of insurance must limit the annual out-of-pocket expenses to specified limits and may not establish lifetime benefit limits for any individual less than $500,000. The coverage may provide for a choice of deductibles but not to exceed $1,000 per covered individual. The plan may exclude coverage for preexisting conditions for a period not to exceed 6 months. The coverage must include the purchase and repair of durable medical equipment.

A qualified pool may charge a premium rate expected to be self-supporting, but such premium rate may not exceed 150 percent of

loyers to participate whether or not they
ance plan. Accordingly, only health insur-
ride health insurance plans governed by
to participate in such pools. Because the
t Income Security Act (ERISA) preempts
ed, self-funded health plans have been ex-
mandate to participate in such pools.
ools are financed primarily by beneficiary
nt that the premium revenues are insuffi-
ool are shared among the health insurance
health insurance in the State. However,
laws relating to employee benefit plans,
to the regulation of insurance. Self-funded
ave been found to be exempt from State
preemption. Accordingly, the self-funded
ie losses of the existing pools.

nends Chapter 41 of the Internal Revenue
e for a tax on the wages paid by large em-
nembers of qualified State health insurance
individuals to perform services in a State
ich a pool. The tax is equal to 5 percent of
employer during the taxable year for serv-
State by the employees.
lefined.—A large employer is defined as an
of some 20 days (each day being in different
oyed 20 or more individuals for some portion
loes not include the United States, any State
, any possession of the United States, or any
ality of any of the foregoing (including the
stal Rate Commission), except that the term
onappropriated fund instrumentality of the

tain churches and associated organizations.—
anizations from participation in the State
s which fund procedures that are contrary to

h insurance pool defined.—A qualified health
ined as any organization which: (1) is a non-
tablished pursuant to and regulated by State
large employer doing business in the State to
mber; and (3) makes available (without regard
ll residents of the State not entitled to Medi-
insurance typical of large employer group cov-
el of insurance must limit the annual out-of-
pecified limits and may not establish lifetime
y individual less than $500,000. The coverage
oice of deductibles but not to exceed $1,000 per
The plan may exclude coverage for preexisting
od not to exceed 6 months. The coverage must
and repair of durable medical equipment.
ay charge a premium rate expected to be self-
premium rate may not exceed 150 percent of

average premium rates for individual standard risks in the State for comparable coverage.

State health insurance pools may deny coverage for some or all services or other costs relating to abortions.

The organization shall assess losses of the pool equitably among all participating members.

The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico.

(e) Establishment of qualified State health insurance pools.—Congress intends that each State shall establish a qualified health insurance pool by not later than January 1, 1988, or, if later, the end of the first regular State legislative session that begins after the enactment of this Act.

Effective date.—Applies to taxable years beginning on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

2. COBRA TECHNICAL AMENDMENTS RELATING TO CONTINUATION OF EMPLOYER-BASED HEALTH INSURANCE COVERAGE (SECTION 10252 OF HOUSE BILL)

Present law

COBRA amended the Internal Revenue code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose their group health insurance coverage as a result of specified qualifying events. Qualifying events include: death of the covered employee; termination or reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or a dependent child ceasing to be a dependent child under the plan.

COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act.

(a) Modification of coverage.—All qualified beneficiaries who would otherwise lose coverage as a result of a qualifying event are entitled to elect continuation coverage. The continuation coverage must be identical to the coverage provided under the plan to similarly situated beneficiaries for whom a qualifying event has not occurred.

(b) Maximum period of continuation coverage.—The continuation coverage period must extend from the period beginning on the date of the qualifying event and end not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events.

(c) Grace period for payment of premiums.—The plan may require payment of a premium. No coverage need be provided under the plan if the beneficiary fails to make timely premium payments.

(d) Election by beneficiaries.—Each qualified beneficiary may elect continuation coverage. If the qualifying beneficiary is the covered employee (in the case of separation from service or a reduction of hours) or the spouse of the covered employee, the election is deemed to include election on behalf of any other qualified beneficiary who would otherwise lose coverage.

(e) Notice requirement.—The employer of any employee covered under a group health plan must notify the plan administrator within 30 days of the qualifying event in the case of the death of the employee, separation from service or reduction of hours of the employee, or the commencement of entitlement to Medicare benefits. In the case of other qualifying events, the covered employee or qualified beneficiary is responsible for notifying the plan administrator that a qualifying event has occurred. However, no time limit is specified in such events.

House bill

(a) Modification of coverage.—Amends the Internal Revenue Code to provide that if coverage is modified under the plan for similarly situated beneficiaries, such coverage shall be modified for all qualified beneficiaries.

(b) Maximum period of continuation coverage.—Amends the Internal Revenue Code to provide that in the case of a qualified beneficiary with respect to whom more than one qualifying event has occurred, the maximum period of coverage may be extended, but in no event may the coverage exceed a 36 month period (other than the period applicable to bankruptcies as described in section 10253 of the House bill; see item XX).

(c) Grace period for payment of premiums.—Amends the Internal Revenue Code to provide that the grace period for making timely payments is the longer of 30 days, the period the plan allows employees, or the period the insurance company allows the plan or employer, whichever the case may be.

(d) Election by beneficiaries.—Amends the Internal Revenue Code to clarify that each qualified beneficiary is entitled to make a separate election with respect to continuation coverage and among the types of such coverage available under the plan.

(e) Notice requirement.—Amends the Internal Revenue Code to provide that in the case of qualifying events for which the coverage employee or qualified beneficiary is responsible for notifying the plan administrator, such notice must be made within 60 days of the qualifying event.

Effective date.—Effective as if the amendments had been included in COBRA.

Senate Amendment

No provision.

Conference agreement

(a) Modification of coverage.—The conference agreement does not include the House provision.

ent of premiums.—The plan may require
o coverage need be provided under the
to make timely premium payments.
aries.—Each qualified beneficiary may
e. If the qualifying beneficiary is the cov-
e of separation from service or a reduc-
e of the covered employee, the election is
on behalf of any other qualified benefi-
lose coverage.
-The employer of any employee covered
an must notify the plan administrator
lifying event in the case of the death of
from service or reduction of hours of the
cement of entitlement to Medicare bene-
ualifying events, the covered employee or
sponsible for notifying the plan adminis-
ent has occurred. However, no time limit

verage.—Amends the Internal Revenue
coverage is modified under the plan for
aries, such coverage shall be modified for

continuation coverage.—Amends the In-
ovide that in the case of a qualified bene-
nom more than one qualifying event has
eriod of coverage may be extended, but in
ge exceed a 36 month period (other than
ankruptcies as described in section 10253
XX).
ment of premiums.—Amends the Internal
that the grace period for making timely
f 30 days, the period the plan allows em-
le insurance company allows the plan or
case may be.
aries.—Amends the Internal Revenue Code
fied beneficiary is entitled to make a sepa-
t to continuation coverage and among the
ailable under the plan.
—Amends the Internal Revenue Code to
f qualifying events for which the coverage
eneficiary is responsible for notifying the
notice must be made within 60 days of the

ve as if the amendments had been includ-

erage.—The conference agreement does not
ion.

(b) Maximum period of continuation coverage.—The conference agreement does not include the House provision.

(c) Grace period for payment of premiums.—The conference agreement does not include the House provision.

(d) Election by beneficiaries.—The conference agreement does not include the House provision.

(e) Notice requirement.—The conference agreement does not include the House provision.

3. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES (SECTION 10253 OF HOUSE BILL)

Present law

COBRA amended the Internal Revenue Code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose coverage as a result of specified qualifying events.

COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act.

(a) Loss of coverage of retiree through bankruptcy.—The reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or dependent child ceasing to be a dependent child under the plan.

(b) Period of continuation coverage.—The continuation coverage period must extend from the period beginning on the date of the qualifying event and ending not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events. Continuation coverage may be terminated on the date on which the qualified beneficiary becomes entitled to Medicare.

(c) Definition of qualified beneficiary in reorganization cases.—A qualified beneficiary is defined as the covered employee of a group health plan (in the case when the qualifying event is the termination or reduction in hours of the employee) and any other individual who, on the day before the qualifying event, was a beneficiary under the plan as the spouse or dependent child of the employee.

House bill

(a) Loss of coverage of retiree through bankruptcy.—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding, commencing on or after July 1, 1986, is considered a qualifying event for continuation coverage with respect to the employer from whose employment the covered employee retired at any time, if such an event resulted in the substantial elimination of coverage for specified qualified beneficiaries within 1 year before or after the filing of the bankruptcy.

(b) Period of continuation coverage.—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding on or after July 1, 1986, which results in retirees' substantially losing health insurance coverage is a qualifying event, in

which case, the maximum period of continuation coverage is life for the retiree or the retiree's widow. After the death of the covered retiree, the maximum period of continuation coverage is 36 months for the surviving spouse and dependent children. In the case of a Title XI bankruptcy as a qualifying event, entitlement to Medicare benefits does not terminate the period of entitlement to continuation coverage.

(c) Definition of qualified beneficary in reorganization cases.—Amends the Internal Revenue Code to provide that in the case of a Title XI bankruptcy as a qualifying event, the term qualified beneficiary includes a covered employee who had retired on or before the date of substantial elimination of coverage, and any other individual who, on the day before such qualifying event, is a beneficiary under the plan as the spouse or dependent child of the employee or as the surviving spouse of the employee.

Effective date.—In general, the amendments are effective as if they had been included in section 10001 of COBRA. Notwithstanding this effective date and section 10001 of COBRA, the amendments made by this section and section 10001 of COBRA shall apply in plan years ending during the 12 month period beginning July 1, 1986, but only with respect to a qualifying event of Title XI bankruptcy, and the qualifying event of death of the covered employee occurring after a Title XI bankruptcy. The section defining Title XI bankruptcy as the qualifying event applies to covered employees who retired before, on, or after the date of enactment.

Senate amendment

No provision.

Conference agreement

(a) Loss of Coverage of Retiree Through Bankruptcy.—The conference agreement includes the House provision with an amendment making a conforming amendment to Title I of ERISA. Because the continued access to private health insurance provision contained in COBRA, which this provision expands, amended both the Internal Revenue Code and ERISA, the conferees believe that an ERISA conforming amendment is appropriate. The conferees wish to clarify that upon the filing for Title XI bankruptcy retirees who have had their health benefits terminated or substantially reduced within one year of the filing for bankruptcy by the employer are entitled to buy the health coverage they had prior to the termination or substantial reduction in their health benefits.

(b) Period of Continuation Coverage.—The conference agreement includes the House provision with an amendment to include a Title 1 ERISA conforming amendment.

(c) Definition of Qualified Beneficiary in Reorganization Cases.—The conference agreement includes the House provision with an amendment to include a Title 1 ERISA conforming amendment.

period of continuation coverage is life
ee's widow. After the death of the cov-
n period of continuation coverage is 36
spouse and dependent children. In the
tcy as a qualifying event, entitlement to
terminate the period of entitlement to

ed beneficary in reorganization cases.—
nue Code to provide that in the case of a
ualifying event, the term qualified bene-
employee who had retired on or before
nination of coverage, and any other indi-
fore such qualifying event, is a benefici-
spouse or dependent child of the employ-
se of the employee.
ral, the amendments are effective as if
section 10001 of COBRA. Notwithstand-
d section 10001 of COBRA, the amend-
ion and section 10001 of COBRA shall
g during the 12 month period beginning
respect to a qualifying event of Title XI
fying event of death of the covered em-
Title XI bankruptcy. The section defining
e qualifying event applies to covered em-
, on, or after the date of enactment.

Retiree Through Bankruptcy.—The confer-
the House provision with an amendment
endment to Title I of ERISA. Because the
e health insurance provision contained in
sion expands, amended both the Internal
A, the conferees believe that an ERISA
s appropriate. The conferees wish to clari-
or Title XI bankruptcy retirees who have
fits terminated or substantially reduced
filing for bankruptcy by the employer are
th coverage they had prior to the termina-
tion in their health benefits.
tion Coverage.—The conference agreement
ision with an amendment to include a Title
endment.
fied Beneficiary in Reorganization Cases.—
ent includes the House provision with an
Title 1 ERISA conforming amendment.

V. Revenue Provisions

1. Extend Medicare Coverage and Hospital Insurance Tax to State and Local Government Employees

Present law

In the Consolidated Omnibus Budget Reconciliation Act (COBRA), P.L. 99-272, Medicare coverage and the corresponding hospital insurance payroll tax were extended on a mandatory basis to State and local government employees hired after March 31, 1986. COBRA also authorized States to elect, by voluntary agreement with HHS, to extend Medicare coverage to State and local government employees hired prior to April 1, 1986.

For Medicare-covered employees, the hospital insurance tax rate for 1986 is 1.45 percent on the employer and 1.45 percent on the employee, applicable to wages up to $42,000 (Code secs. 3101, 3111, and 3121(a)).

House bill

No provision.

Senate amendment

The Senate amendment extends Medicare coverage on a mandatory basis to employees of State and local governments who are not otherwise covered for Medicare under present law. These employees and their employers will become liable for the hospital insurance portion of the FICA tax, and the employees will earn credit toward Medicare eligibility based on their covered earnings. (The optional Medicare coverage provision enacted in COBRA is terminated.)

Under the Senate amendment, the collection of the hospital insurance tax with respect to newly covered employees is to be carried out in the same manner as was provided in COBRA with respect to employees hired after March 31, 1986.

The Senate amendment is effective for services performed after April 30, 1987.

Conference agreement

The conference agreement does not include the Senate amendment.

2. Deposits of Social Security Contributions by State and Local Government Employers

Present law

A State that enters into a voluntary agreement with HHS to provide social security coverage for its employees and employees of its political subdivisions must collect and deposit the employer and employee social security tax payments on behalf of both the State and local entities. The local entities first pay over the social security taxes to the State, which must verify and consolidate the payments. The State then deposits these amounts, plus the appropriate tax payments with respect to its own employees, with the Federal Government on a twice-a-month deposit schedule.

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

CMS LIBRARY
3 8095 00007726 9